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No. 99-830

Supreme Court, U.S.
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In The

Supreme Court of the United States

DON STENBERG, Attorney General of the State of Nebraska, et al.,

Petitioners,

v.

LEROY CARHART, M.D.,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX VOLUME II, PAGES 241 TO 481

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

TRANSCRIPT OF TRIAL PROCEEDINGS,
BEFORE THE HONORABLE RICHARD G. KOPF,
UNITED STATES DISTRICT JUDGE

* * *

[p. 3] THE COURT: Good morning. We are on the record in Carhart vs. Stenberg. Would counsel enter their appearance, please?

MR. HELLER: Simon Heller, Center For Reproductive Law and Policy for the plaintiff.

MR. HUG: Jerry M. Hug, Omaha, Nebraska, for the plaintiff.

MR. SMITH: James D. Smith, Assistant Attorney General, for the defendant Stenberg, Dunning, and Charles Andrews.

THE COURT: Good morning, counsel. You were good enough to visit with me in chambers. We have set a briefing schedule, and we'll enter an order as we agreed in chambers on the briefing schedule. My understanding is that we will not have formal oral argument, but you'll submit the matter on the briefs. However, I may have some questions after the end of the trial, and if so, I will address them to you at that time orally.

I do want, as I indicated to counsel for the plaintiff, I do want to know what the plaintiff's position is in terms of whether or not this is as an applied challenge or a facial challenge or both. I have some uncertainty about whether the plaintiff is – whether a single plaintiff can

mount a dual as applied challenge and a facial challenge, so we need to know that clearly in the briefs.

[p. 4] I think that is all we need to put on the record at this time. Are counsel ready to proceed?

MR. SMITH: Yes. There is one other matter on one exhibit, Your Honor, that was not received by the pretrial order.

THE COURT: Well, yes. I was just talking now about preliminary matters. My understanding is that all of the exhibits that are attached to the pretrial order that have been received pursuant to the pretrial order are now offered and received, is that right?

MR. SMITH: That's correct, and I think the report would probably need some clarification as to what Exhibit 33 is since the record doesn't reflect that yet.

THE COURT: I'm not talking about Exhibit 33 yet, counsel.

MR. SMITH: Okay.

THE COURT: But all of the 1 through 32 are received in evidence, is that right?

MR. HELLER: Yes, Your Honor.

MR. SMITH: That's correct.

THE COURT: Now, the parties, I understand, additionally stipulate that Exhibit 33 may be received in evidence. Does the clerk have Exhibit 33?

COURTROOM DEPUTY: Yes.

THE COURT: All right. Give it to me, please. I [p. 5] hold in my hand counsel Exhibit 33 which on its

first page purports to be a memorandum to co-sponsors of LB23 from Senator David Maurstad dated April 10, 1997, preliminary information on partial-birth abortion, and then there are various pages attached to that memorandum. All right. That's what I understand that Exhibit 33 is.

MR. SMITH: Yes. Exhibit 33 actually is, in its entirety, comes from the internal legislative file of Senator David Maurstad, comes from his file for LB23, and there are two colored pages that are part of Exhibit 33, and what those colored pages denote, three separate documents. In other words, they are Exhibit 33.

THE COURT: Oh. I see.

MR. SMITH: After the first colored page is one document, after the colored page it's another document, after the next colored page would be the third document, all three of which documents in Exhibit 33 came from Senator Maurstad's legislative file.

THE COURT: So really there are three documents. The first is a memorandum and attachment I just indicated to co-sponsors of LB23 from Senator David Maurstad. The next is – there follows a red page followed by another memorandum judiciary committee memorandum to KAB from JSP dated April 11, 1997, re: constitutional argument re: LB23, partial-birth abortion, followed by another red piece of paper and another [p. 6] judiciary committee memorandum to KAB to JSP dated April 11, 1997, re: committee amendment to LB23.

MR. SMITH: That's correct.

THE COURT: Now, are the parties in agreement that that document maybe received in evidence?

MR. HELLER: Yes, Your Honor.

MR. SMITH: Yes, Your Honor.

THE COURT: All right. It is received in evidence. Okay. I take it then all of the paper evidence is now in, is that right?

MR. HELLER: That's correct, Your Honor.

MR. SMITH: That's correct.

THE COURT: All right. The plaintiff may proceed.

MR. HELLER: Thank you, Your Honor. Like to call Phillip Stubblefield.

PHILLIP STUBBLEFIELD,
PLAINTIFF'S WITNESS, SWORN

THE COURT: You may inquire.

DIRECT EXAMINATION

BY MR. HELLER:

Q Thank you, Your Honor. Good morning. Would you please tell me, what is your profession?

A I'm a physician.

Q Where did you receive your medical degree?

A Harvard Medical School.

Q What year was that?

[p. 7] A 1966.

Q Did you, after medical school, complete an internship?

A Yes, I did.

Q And where was that internship?

A University of Michigan, Ann Arbor.

Q After your internship, did you do any further medical training?

A Yes, I did. I did a three-year residency in obstetrics and gynecology at Boston Hospital for Women.

Q Have you received any board certification?

A Yes, in obstetrics and gynecology.

Q Are you licensed to practice medicine in any states?

A Yes, in Massachusetts.

Q What is your current employment as a physician?

A I'm a professor and chairman of the department of obstetrics and gynecology at Boston University School of Medicine and director of obstetrics and gynecology for the Boston Medical Center.

Q What is distinction between the Boston Medical Center and Boston University?

A The hospital is a private, nonprofit corporation distinct from the university. It's not owned by the university.

Q Is the hospital a teaching hospital?

A Yes, it is.

[p. 8] Q Could you just explain to the Court what a teaching hospital means?

A It's a hospital that accepts either residents in training in specialties or medical students or both. Most teaching hospitals have both. We have medical students from our university rotating through my service. At anytime, we have 25, 26 medical students. And in addition, in all of the major disciplines, we have training programs where physicians who have completed medical school do their post-graduate training as necessary to be certified in a particular discipline.

Q How many residents do you have in your department?

A Currently I have 19.

Q Prior to your position at Boston University and Boston Medical Center, what position did you hold?

A My previous position was chief of obstetrics and gynecology at the Maine Medical Center in Portland, Maine. I also held a professorship at the University of Vermont at the same time.

Q Can you describe the Maine Medical Center? What is that?

A Maine Medical Center is the largest hospital in the state of Maine, a primary and secondary hospital for the community around it and tertiary hospital for the state, providing pretty much all medical services that exist. We

had [p. 9] independent residencies. My service at that time, we had 12 residents in OBGYN and rotating medical students from the University of Vermont.

Q Can you describe for me your current medical practice?

A Yes. I spend most of my time being an administrator and teacher, doing a little investigation from time-to-time, but I do still practice clinically. I spend half a day a week in our faculty group, private practice, and half a day a week in our resident clinic in the hospital with my residents seeing patients. I cover the labor floor for deliveries once or twice a month for a 24-hour period and also operate half a day or a day a week depending on what needs to be done.

Q You mentioned doing some teaching currently. What does your teaching role consist of?

A Oh, it's varied. Some of it is actual classroom instruction, lectures, seminars for medical students. More of it in terms of time is spent seeing patients with the residents, helping them to take care of their patients, operating with them, teaching them how to operate, doing deliveries with them, teaching them how to manage in labor and delivery.

Q When did you receive your board certification in obstetrics and gynecology?

A In 1975.

Q Have you, since 1975, been in an active practice [p. 10] throughout that period of time?

A Yes, I have.

Q Do you perform abortions, or have you performed abortions as part of your medical practice?

A Yes.

Q In your current practice, do you perform abortion procedures yourself?

A Yes.

Q Do you also supervise?

A Yes.

Q Could you give me an estimate of currently, on an annual basis, how many abortions you supervise in your current position approximately?

A Well, the service for which I am responsible provides 1,500, 2,000 abortions a year. My direct involvement is to spend a half a day probably twice a month with the residents where I will do two or three abortions myself. The others I will be coaching residents.

Q That's part of their training?

A Yes.

Q In what type of setting are the abortions you supervise and perform done; that is, are they inpatient in a hospital, or are they own [sic] an outpatient basis?

A They are both.

Q Going back to your position at Maine Medical Center, did [p. 11] you also perform abortions there?

A Yes, I did.

Q Can you tell the Court approximately how many abortions you did on an annual basis or how many abortions you supervised on an annual basis there?

A My involvement in Maine was that one-half day every week I supervised the residents. We performed six, eight, 10 procedures, and then in addition, in my private practice, I offered D & E abortion through about 22-and-a-half weeks of pregnancy, primarily for women with illness or with fetal malformations.

Q In your current position at Boston Medical Center, do you have a cutoff after which you won't do abortions?

A The hospital policy limits us to 20 weeks as a cutoff.

Q Prior to your position in Maine Medical Center, what position did you hold?

A My immediately-previous position was chief of obstetrics and gynecology for the Mount Auburn Hospital in Cambridge, Massachusetts.

Q And were there abortions performed at that hospital?

A Yes.

Q Prior to your position at Maine Medical Center, were you doing teaching?

A Yes.

Q Where were you teaching?

[p. 12] A I was teaching at Maine Medical Center, but at Mount Auburn Hospital while we didn't have

residents, we did have medical students rotating from Harvard Medical School.

Q Have you held any teaching positions at Harvard Medical School?

A Yes. When I left there to go to Maine, I was in the – clinical associate professor.

Q In your position. I'm sorry. Was that –

A Yes, I am finished.

Q In your position while you were at Harvard, what period of time were you at Harvard Medical School?

A I have to stop and think about that. I completed my residency in '73, and I maintained – I had a Harvard appointment probably as an instructor or an assistant professor which I maintained over the years until I left Boston, I believe it was '88, to go to Maine, so '73 through '88.

MR. HELLER: May I approach the witness, Your Honor.

THE COURT: You may.

BY MR. HELLER:

Q Dr. Stubblefield, I would like to show you what's been received in evidence as Exhibit 29 and just ask you to identify that.

A Yes, that's my curriculum vitae.

[p. 13] Q Would you take a moment to look over, and is it current as of today, do you know?

A Actually, it's a few months behind. I have a few more publications that aren't on this version.

Q But it's current as to your current position?

A Yes. Yes.

Q During your time at Harvard from 1973 up to 1988, I believe you said, did your medical practice include abortions throughout that period as well?

A Yes, it did.

Q And did that include both performing and supervision of abortions?

A Yes, it did.

Q Do you currently teach abortions? I think you indicated that you trained and teach abortions?

A Yes, I do.

Q What techniques of abortion do you teach?

A Vacuum curettage, first trimester; D & E procedure early mid trimester; and my service also provides a labor induction method that we employ generally from 17 to 20 weeks.

Q At Maine Medical Center, did you teach those same techniques, or were there other techniques that you would teach there?

A I didn't – We really did very few of the labor induction abortions. D & E was primarily what I practiced [p. 14] and taught.

Q You indicated, I think, at Maine Medical Center abortions were offered through 22-and-a-half weeks, is that right?

A Yes.

Q For those later abortions, what techniques would you use?

A D & E, most of them were done by me, and I did a D & E technique.

Q Are you currently a member of any professional organizations?

A Several.

Q Can you tell me some of the more prominent ones that come to mind?

A The American College of Obstetricians and Gynecologists, the Association of Professors of Obstetrics and Gynecology, Counsel of the University Chairs in Obstetrics and Gynecology, Counsel on Resident Education in Obstetrics and Gynecology, National Abortion Federation.

Q Can you start with, just briefly, what is the American College of Obstetricians and Gynecologists?

A It is a professional group. To be admitted as a Fellow, you have to be board certified in obstetrics and gynecology, a separate organization and reviewed, and fill out your forms and present your credentials. It's an organization that is [p. 15] devoted to advancing the interests of our women patients through educational meetings, sessions, production of committee opinions and reports, and guidance for practice.

Q On your CV, you listed a number of published articles?

A Yes.

Q Have any – Do any of those articles focus on abortion?

A Yes.

Q Have the articles you've published on abortion been peer reviewed?

A Well, in my CV, I give two lists. The first list are the peer-reviewed articles that represent some kind of actual study that I was involved in. The second list are textbook chapters, for the most part, or journal review articles where I have reviewed the work of other people, but it doesn't represent my original contribution. Those that are published in the journals are peer reviewed. Textbook chapters are not.

Q What does it mean for an article to be peer reviewed? Do you know?

A Well, the way of operating of medical journals [sic] is that an article is submitted, and the editor will read it himself, but will typically send it to three or four people that the editor picks who were thought to be experts in this specific field. The reviewers are to read the article and give an opinion back to the editor as to whether they think the [p. 16] methodology is valid, the scientific content is valid, how well is it written, does it ring true. Of articles that are submitted to medical journals, depending on the journal, maybe five or 10% are going to be published. The others are going to be rejected,

you know, because the reviewers thought they were not worthwhile or badly done or not important.

Q Have you yourself peer reviewed proposed articles that other authors have written?

A Yes I regularly do that.

Q Dr. Stubblefield, would you describe for me the methods of abortion that are used in the first trimester of pregnancy?

A Yes. In this country, for the most part, the first trimester abortions are performed by a vacuum curettage, although in very recent years, there have been introduced techniques that involve medications that will induce abortion as well. But the vast majority are still performed by the surgical technique, fairly simple in concept. The cervix or the neck to the womb is a long, thin tube of connective tissue with muscle at its upper end. That cervical opening needs to be dilated. That can be done with metal dilators which are tapered rods. If you envision the cervix as a tunnel, one takes the dilators which start smaller than this and are tapered, not blunt, and gently inserts that through the cervical canal to stretch it. Then a larger dilator is [p. 17] used to stretch it a little more, and serially dilating, stretching the cervix until an adequate diameter is reached, and then a hollow vacuum tube is inserted into the uterine cavity and attached to a vacuum source, typically an electric pump, and the vacuum is used to evacuate the uterine content.

As I mentioned, the other first trimester methods that are used are medical methods. The famous RU 486, an

anti-progesterone used in combination with a Prostaglandin hormone, also a drug called Methotrexate can be used instead of the RU 486. Methotrexate has the advantage of being FDA approved and available in the United States. RU 486 is not. There are studies under way with these and other drugs to look for safe alternatives to the cervical procedure.

Q Thank you. I just wanted to ask a couple of questions about what you described. The cervix, can you tell the Court where the cervix is located in the woman's anatomy?

A It begins at the upper end of the vagina. Do you have a diagram?

MR. HELLER: Your Honor, may I approach?

THE COURT: Yes.

MR. HELLER: We've given to the State an anatomical diagram, I want to provide to the Court as a guide but not as an exhibit.

THE COURT: Why don't we – It's my practice to mark those. Let's mark them as a demonstrative exhibit.

[p. 18] COURTROOM DEPUTY: It will be number 34.

THE COURT: All right. Let's just mark it as Exhibit 34, anatomical drawing. Now, counsel, do you have an objection to me looking at Exhibit 34?

MR. SMITH: No, not for purposes of a demonstrative exhibit.

THE COURT: All right.

MR. HELLER: If I may hand a copy of it to the witness?

THE COURT: That will be fine. Thank you.

BY MR. HELLER:

Q Could you describe on the diagram for the Court the location of the cervix and how it –

A Well, this is two pictures. The upper one shows the upper genital tract organs of the woman and without showing the rest of the body. This is the uterus, this whole thing. The lower third or so of the uterus is the cervix or neck is what the word means. This is the corpus or body of the uterus up here. These are the fallopian tubes that convey the sperm and the egg. This is the ovary where the eggs come from, and the cervix continues with the vagina. You can see here the side walls of the vagina. This would be the cervical opening into the vagina. In this picture at the bottom shows how the organs would look in place in the woman's body with the abdominal wall here, the backbone [p. 19] there, the rectum pictured back here, and then this is the vagina and the uterus in situ, and the bladder, and then intestine lying above it.

Q Am I correct in saying that the cervix sort of separates the uterus from the vagina in a sense?

A In some sense, yes. The cervix is the lower third of the uterus.

Q So at the end of the cervix is where the vagina begins, is that correct?

A Correct.

Q In the first trimester procedure you described, how is the – What is it that results in termination of the pregnancy?

A With a surgical procedure, it's the introduction of the hollow tube with the vacuum so that the negative pressure is created within that hollow tube, and the pregnancy tissue is pulled out into the tube into the vacurette, it's called.

Q And I assume the fetus is removed through that tube?

A Correct.

Q Is the tube placed into the woman's uterus?

A Yes, through the cervix into the uterine cavity.

Q And how long of a tube is it?

A About that long, about 10 inches, perhaps.

Q So it extends from within the woman's uterus to outside the woman's body?

[p. 20] A Correct.

Q In that procedure where you are using suction to remove the fetus, does the fetus come out in one piece or in fragments?

A Generally in fragments. Occasionally, it can come out intact. Depends on the size of the cannula. We typically use the smallest size that will work, depending on the length of the pregnancy. For example, if the pregnancy is about eight weeks, typically we'll use a seven or

eight millimeter cannula. Every now and then, I have had the experience of thinking that the uterus is larger, perhaps, because the woman had fibroids which are smooth muscle tumors of the wall of the uterus or just that the woman has had many, many pregnancies, so the uterus has remained larger and have [sic] dilated more and perhaps used a 10 millimeter or 11 millimeter diameter cannula for a pregnancy, and the result of that is is that the fetus would sometimes come out intact.

Q Can you just define for the Court what a cannula is?

A The cannula is the hollow tube, that I referred to earlier, that's introduced into the uterus to evacuate the pregnancy.

Q In a first trimester procedure, abortion procedure, surgical procedure that you've described, is the fetus living at the beginning of the procedure?

A Yes.

[p. 21] Q How would you determine that it is living at the beginning if you wanted to?

A If you wanted to, you could use an ultrasound, depending how early the pregnancy is. You can, with transvaginal ultrasound, see the fetal heartbeat beating by five to six weeks from the last menstrual period.

Q Can fragments of the early pregnancy that come out through that cannula, can a fragment come out while the fetus is still living?

A Yes.

Q For example, could a fetal, let's say at eight weeks, are there – Does the fetus have arms and legs and hands?

A Yes.

Q Could a leg come out through the cannula and the remainder of the fetus still be in the uterus?

A Yes, it could.

Q Could the suction through the tube remove the head of the fetus first?

A Yes, it could.

Q Could it remove the contents of the head, of the fetal head?

A I don't think that would happen in the first trimester because the tissues are soft, and I think that the whole head would collapse end everything. The head would be extracted as a piece.

[p. 22] Q If there is an intact fetus which you said sometimes might come through the tube, can that be living after it's outside the woman's uterus?

A Yes, it could be. It wouldn't live for very long, but yes, it could be.

Q How long does the entire vacuum curettage procedure take from the time that the tube is inserted into the woman's uterus until the procedure is done?

A It depends somewhat on gestational age and the size of the cannula, but it's on the order of two, two to five minutes, something like that.

THE COURT: Counsel, for what it's worth, and you know probably better than I do, there is a debate about what living means. I leave it to you.

BY MR. HELLER:

Q I was just about to ask about that. Dr. Stubblefield, can you tell me, what are the criteria for determining whether a fetus is living?

A Well, as the judge just stated, that that is something of a difficult question. We have agreed-upon criteria for death of an adult or of a child, for that matter, having to do with absence of brain waves on two electroencephalograms at some interval apart as constituting brain death. In order to define it in those circumstances, there isn't any definition that I'm aware of that has been agreed upon in the [p. 23] case of a pregnancy termination. The things that you can objectively attest to, whether the heart is beating. We have an intact fetus with a heart beating, then the fetus is clearly alive.

Q At what point in pregnancy can fetal heartbeat be detected?

A About five or six weeks.

Q Can the heartbeat continue to beat after a portion of the fetus has been removed, say, in the first trimester procedure?

A Yes, it could.

Q How would you determine that it's still continuing to beat?

A Well, if you were to stop the procedure and do a transvaginal ultrasound, you could demonstrate it.

Q If I understand correctly, does that mean that a doctor could begin the suction procedure, remove a fragment of the fetus, which might be an arm or a leg, some other piece, and then do an ultrasound and see that the fetal heartbeat is still going?

A Yes, it could be done.

Q Thank you. Is there – are there – Different question. How would you make a determination that a fetus has died in the uterus, or do you make such a determination?

A Yes, you do. This is not an uncommon problem in a [p. 24] pregnancy that the patient prevents – presents for a prenatal visit, for example, and the uterus has not grown since the previous visit, measuring by height above the pubic bone, and one would obtain an ultrasound and visualize the heart and see that it's not beating, so you know the fetus has died.

Q So if – Is it always the case that you observe on the ultrasound that there is no heartbeat, does that necessarily mean the fetus is dead?

A Well, that's also not a short answer. We have, on occasion, I have seen, on occasion, in obstetric emergencies, the one that comes to mind is called the ruptio placenta where the placenta separates from the uterine wall. The fetus no longer gets any fresh oxygenated blood, and it starts to die, and we have seen situations where the patient comes in, the abruption has begun, it has moved to complete abruption as the patient was being wheeled onto the labor delivery floor from the ambulance. No heartbeat present. Cesarean section done

with a few minutes and the baby resuscitated, so it depends on the timing. If the fetus has, in fact, just died, it may be that one can resuscitate it, and we try real hard in the third trimester to do just that.

Q In the first trimester, going back to that example, if a fragment of the fetus had been removed and the heartbeat was still detectable but then stopped, is there any way to [p. 25] resuscitate that fetus?

A No.

Q Could you explain why?

A We're talking about a fetus that is about an inch long. We do not have the technology, the instruments to deal with an inch-long fetus leg torn off, now delivered.

Q Going back to, again, the vacuum curettage procedure you described, at what stage of pregnancy would that procedure be used?

A The vacuum curettage technique, as I described it, can be used up to 15 or 16 weeks. Depends on – There are alternatives. If one chooses to use the large bore vacuum cannula available up to 16 millimeters in diameter, then one can terminate at 15- to 16-week pregnancy with the cannula only. One can choose to use a somewhat smaller cannula, 12 millimeters or 14 millimeters, plus the forcep which is an instrument, sort of like a pair of pliers only a little different, that you insert through the cervix into the uterine cavity and use to grasp pieces of fetus and placenta and pull them out.

Q At what point in pregnancy might you start using forceps?

A Some physicians at 13 weeks would use the forceps and a 12 millimeter cannula. Others would use a 14 or 16 millimeter cannula and not use forceps. Beginning around 16 [p. 26] weeks, you're going to always need to use the forceps. The cannulas are not enough.

Q I want to go back a little bit over some of the terms you have used. When you refer to 13 weeks or 16 weeks, 14 weeks, can you tell the Court what definition of where you are measuring the weeks from?

A Yes. That also is not a short answer. Typically, we use menstrual weeks, referring, really, using a convention that we've agreed upon that defines pregnancy as beginning on the first day of the last menstrual period. We know that to be not true. In fact, in this sort of typical 28-day menstrual cycle ovulation is about day 14, and conception needs to occur within 12 to 24 hours after the egg is released or the egg dies. So that conception, in terms of fertilization, occurs around day 14. It's six more days before the fertilized embryo begins to implant in the wall of the uterus and you can measure the pregnancy hormone in the mother's system, so about day 20, 21 is implantation, so that, in fact, when we say a six-week pregnancy, what we are really talking about is one that is four weeks from fertilization.

Q Is there a way – How do you determine the weeks, how far along the pregnancy is? What techniques do you use to determine that?

A You ask the pregnant woman when her last normal [p. 27] menstrual period was. You count from the first day of the last period. That's the beginning of it. You can do a bimanual exam. That means two hands with two

fingers in the woman's vagina feeling abdominally. You can feel how big the uterus is. An experienced physician can tell most women, probably, give or take two or three weeks, how far along the pregnancy is from that examination, but that can be thrown off by many different things. For the last 20 or so years, we have had ultrasound, sound waves which will visualize parts of the fetus, and we can measure the size of those parts, and then we can go to charts that have been developed by observing hundreds of pregnancies, and we can use those measurements to say this fetus is the same size as the average fetus is at such-and-such weeks of pregnancy. We can measure the diameter, for example, of fetal head consistently, and we can relate that to a chart to say this fetus is 10 weeks, meaning this fetus's head size diameter is the same as the average fetus at 10 weeks.

Q Another thing you talked about was different sizes of cannulas, and you indicated that there are smaller and larger ones. Is there a reason to use a smaller or larger one for a particular woman?

A Yes. The cannula size decision is a trade off like pretty much everything else in life. If you could use a large cannula with no risk, that would be preferable because [p. 28] the evacuation of the uterus will happen more quickly with less blood loss, but in order to be able to insert the large cannula, you're going to have to dilate the cervix more. There is some risk of injuring the cervix, so our convention is to use minimal dilatation and small cannulas for early pregnancy and gradually increase the cannula size as the pregnancy progresses. One convention is to use a cannula size in millimeters in diameter that fits the menstrual weeks, so if it's an eight-week

pregnancy, eight millimeters if it's a 12-week pregnancy, 12 millimeters. In fact, you could use a 10 millimeter cannula perfectly well and evacuate a 12-week pregnancy just about as quickly, if you are experienced and know what you're doing.

Q Have you yourself used the vacuum procedure you've described?

A Yes.

Q Now, we were starting to talk about procedures after about 13, 14, 15 weeks, and you were talking about use of forceps. Have you yourself used forceps in abortion procedures?

A Yes.

Q Is a procedure involving forceps, does it have – Is it called something different or is it still called vacuum curettage?

A It is typically called a D & E, dilatation and [p. 29] evacuation.

Q Does the D & E involve any use of suction at all?

A It usually does. The D & E procedure as practiced in this country typically involves slow, gentle dilatation of the cervix using osmotic dilators rather than the steel rods and forcible dilatation I described with first trimester. The reason for doing that with the more advanced procedures is that you need more dilatation of the cervix, and you would like to accomplish that without injuring the cervix and risking later pregnancies.

Q What sort of – Can you describe for the Court what are osmotic dilators?

A The one that is used most commonly are called laminaria. They are the stem of a seaweed laminaria japonicum. They come to us as little dry sticks about five centimeters in length, two, three millimeters in diameter. When they are placed in water, they take up the water and swell to, oh, three or four times their original diameter, so if one inserts in a patient who is perhaps 16 weeks pregnant, you can insert three or four of those two-millimeter dilators one at a time into the cervical canal, just kind of pack them in gently, and over the course of a few hours, they will swell pulling water out of the cervix, and the cervix will dilate away from those laminaria, so that when you pull them out, the cervix is now considerably dilated, depending on how many [p. 30] laminaria you put in and how long you wait, and then you're then able to put instruments through the cervical canal into the uterus without pushing. You can just gently put them in. That markedly reduces the risk of perforation, of pushing an instrument through the wall of the uterus or of tearing the cervix.

Q In doing a D & E procedure, let's say, at 18 weeks, can you describe in a little bit greater detail what you would actually do with the instruments you would be using?

A Standard D & E is to have a predilated cervix with the laminaria, and then there is some variation as to what is done, but my procedure would be to insert a vacuum cannula, use that to rupture the membranes and drain the amniotic fluid, and rotate the cannula around. Sometimes that will actually begin to separate and pull out part of the placenta. Sometimes a fetal part will come out, and then switch to the forceps, pull the cannula out

and switch to the forceps, reach inside and gently grasp and turn, and then basically tear off pieces of the fetus and pull them out.

Q So you would remove a piece of the fetus as you detach it from the rest of the fetus, is that correct?

A Correct.

Q So you don't actually dismember the fetus in utero, then take the pieces, out?

A No.

[p. 31] Q Is there a reason you can't sort of dismember or disjoin the fetus into smaller pieces in the uterus and take the pieces out?

A That means you would have to introduce into the uterus something that would cut up the fetus, or else put in two forceps and try to dismember the fetus inside the uterus, which would increase considerably your chance that you're going to tear the uterus, perforate the uterus, seriously injure the woman. That is not done. What one does is reach up, grasp what you can, and pull down, and that comes apart. The fetus separates and comes out when you do that.

Q At the beginning of a D & E, is the fetus living?

A Yes.

Q And how would you determine that it's living?

A Ultrasound.

Q What would be some examples of parts of the fetus that might be removed with forceps?

A Leg, arm.

Q So could you remove a leg and have the remainder of the fetus be in a woman's uterus?

A Yes.

Q Could the remainder of the fetus still be alive?

A Yes, it could.

Q How long could, if you know, how long could a fetus in the uterus survive after a leg has been detached?

[p. 32] A I don't know.

Q Could you do the entire procedure with ultrasound observation going on?

A Yes.

Q You talked a little bit about risk of perforation or tearing. What are the major risks of doing a D & E for the woman?

A Well, there are immediate risks that have to do with trauma to the uterus and cervix, laceration or tearing of the cervix during dilating, perforation, pushing an instrument through the cervix or through the wall of the uterus with D & E procedure. Because the uterus is large and soft, it takes some skill to avoid perforation. If one is, if one perforates, one can cause extensive harm. One can badly injure the bowel or bladder or the nearby organs, cause major blood loss and clearly major injury that will have to be surgically repaired with a major surgical procedure.

Q Are there any other significant risks from a D & E other than the ones arising from perforation or laceration?

A Yes. One can have very difficult-to-control bleeding with or without a perforation. One can have what is called uterine attenuate where the uterus does not contract well and there is heavy bleeding during the procedure. There are rare, very serious complications such as amniotic fluid embolism which occurs perhaps one in 10,000 cases. Those are [p. 33] usually fatal, where tissue from the fetus enters the mother's circulation through the big venous openings inside the uterus and travel through her body to the lungs where they cause major troubles. One can also, at the end of the procedure, appreciate what's called DIC, disseminated intravascular coagulopathy where tissue from the fetus, smaller amounts, perhaps, enter the circulation of the mother, trigger clotting within her blood system that uses up the clotting factors, exhausts their supply, so that the patient then begins to bleed heavily and will require a treatment of blood products in order to replenish the clotting factors and stop the bleeding.

Then there are later complications having to do with retained tissue and/or infection. If there is retained pregnancy tissue, there is great risk for infection, and infection can also occur without having retained tissue. We routinely use antibiotics in a preventive way to try and prevent infection. I have listed all of these terrible complications, and I would also add that they are quite rare, fortunately.

Q Looking at a D & E procedure, do you know if that, if you, in general, take into account all these risks, is it safer or more dangerous than childbirth?

A Well, the risk of all abortion procedures has to do greatly with gestational age. First trimester procedures are [p. 34] markedly safer than childbirth, the risk of death from first trimester procedures being considerably less than one maternal death per 100,000 legal-induced abortions in the United States, compared to a maternal mortality rate, that's from pregnancy, that are around seven, eight per 100,000. That risk rises as the gestational age progresses. At 16 to 20 weeks, the risk of death is still somewhat less than the risk of pregnancy, death from abortion. Beyond 20 weeks, 21 weeks, somewhere in there, the reported risk of death from abortions may exceed the risk of death in childbirth. I say may because the number of cases are small, and some of the women who are choosing those late abortions have major life threatening illnesses which put them at far greater risk than other women for death from childbirth.

Q Thank you. How late in pregnancy can a D & E technique be used?

A Well, D & E technique, as I have described it, can be used probably through 23, 24, weeks but it gets progressively more difficult. Fetus is larger, more rigid. The bones are now ossified and are no longer soft cartilage. It becomes much more difficult to perform. As a result of that, people who provide surgical abortion after 20 weeks typically modify the procedure in any of a variety of ways to make it easier to perform and safer for the pregnant woman.

Q How do they modify the technique?

[p. 35] A Well, one of the ways is, the reason we are here today having to do with this recently-evolved intact D & E variation where instead of just reaching up with a forceps and trying to remove pieces of the fetus, one tries to deliver the fetus intact. One way to do that is to use the laminaria, the dilators that I talked about, successive sets of those dilators over two or three days, allowing one set to work overnight, taking them out the next day, putting still more dilators into the now somewhat dilated cervix, and then repeating this a third time so that by then, the cervix is two, three, four centimeters dilated, fairly large opening, without injury to the cervix. Then a medication is given to cause the uterus to begin to contract, typically one of the Prostaglandins although it could be intravenous Oxytocin in high doses. Then depending on how the fetus presents, either through procedures as performed, if the fetus is presenting head first, which is probably more often the case, one can insert an instrument into the fetal skull and allow the brain content to come out. The head then collapses, and one then can pull the whole fetus out of the uterus immediately, and then reach up and pull the placenta out, and the procedure is done very quickly with very little blood loss, very little risk to the mother of perforation.

The alternative is the one which, in the lay press, has been called a partial-birth abortion, where the fetus is [p. 36] either presenting by the breech, that is, feet first or one converts it to a breech by reaching up with fingers or instruments, locating the feet, pulling them down, then pulls feet down, arms down, and then with traction so that the head is now just above the cervical opening,

inserts an instrument, scissors into the skull, and lets the brain tissue come out or aspirates it with a cannula, and the head collapses, and the fetus is delivered. This is a technique that's evolved fairly recently. Prior to that a number of things had been done. Go back historically, perhaps the first was in England where for these late procedures, the surgeon would have, after the cervix was dilated, intentionally rupture the membranes of the amniotic sac, drain the fluid and pull down the umbilical cord if it could be reached, cut it, and then just pack the cervix with gauze and wait two or three days. The fetus, now dead or would die, and begin, to decompose and soften, and the uterus would begin to contract so then the operator would bring the patient back two or three days later and evacuate the uterus. That procedure was done, was reported in the medical literature in England. It has been done to some extent in this country but has been abandoned because it occasionally is associated with very severe infection. One is leaving pregnancy tissue into the uterus and potentially introducing bacteria from below which is not a good idea.

[p. 37] Q Are there any procedures done later in pregnancy that don't involve forceps at all or instruments?

A Yes. There are a variety of labor-induction methods. The first of those to be practical was the use of concentrated salt solution, saline procedure where an amniocentesis is performed, a needle is guided through the mother's abdominal wall, through the wall of the uterus and into the sac of fluid that surrounds the fetus. Some of that fluid is withdrawn and then typically 200 cc's of 20% sodium chloride was instilled into the uterine

cavity. That would produce fetal death and trigger the onset of labor, so that on an average of 30, 35 hours of labor, the patient would expel the fetus and placenta.

Over the years, that technique was modified. The Prostaglandin hormones were introduced which directly caused the uterus to contract. There are a variety of things that can be given by a variety of routes. Initially, they were given by the intra-amniotic injection the same way the saline was given, but then more recently we have had Prostaglandins that could be given intramuscularly or just inserted into the vagina where they are absorbed into the system and will cause labor to begin.

Q How long does that, does a labor induction procedure take?

A Well, that's not a short answer either. The saline [p. 38] method by itself was an average 30, 35 hours, but it could take 70 in some women or longer and didn't always work. The saline can be augmented or added to by adding intravenous Oxytocin which we have had for a long time, or by adding Prostaglandins to make the procedure shorter. With modern Prostaglandin methods, the average time to abortion from when the Prostaglandin therapy is begun is on the order of 15, 16 hours, but that's an average. There are some women that will abort more quickly. There are some that will take much longer.

Q What does the woman experience during the – from the time the Prostaglandin is first given to her until the fetus is delivered?

A Strong uterine contractions, labor pains.

Q And what type of setting is an induction procedure done in?

A Hospital.

Q I'm going to come back to the intact procedure you described, but I first want to ask you, in your career, have abortion methods changed over the course of time? For example, the D & E, has that been the same throughout your practice, or has it changed?

A No. These techniques have evolved over the years as you might expect. Abortion became legal throughout the United States not until '73, although it was allowed in a number of [p. 39] states for a number of indications prior to that. There was very little interest in the medical profession in this country in safe methods for abortion. With legalization, there's a rapid introduction of technologies and a whole array of technologies have been introduced and perfected.

Q I want to ask you whether you consider the intact procedure you described, that is, when the fetus is removed in one piece rather than fragments, do you consider that to be a type of D & E procedure or something altogether different?

A The type of D & E procedure?

Q Could you describe why you consider it a type of D & E procedure?

A Well, it's basically the same instruments, the same process, just a variation and, in fact, the surgeon who made the attempting to – whose goal is to perform an intact D & E often finds that he cannot, that the

anatomy is just such that he cannot do it without avulsing pieces of the fetus.

Q Have you ever used the intact variation of the D & E yourself?

A I have used it in a case that I recall where the fetus was already dead and where I decompressed the head.

Q In a case where the fetus is already dead, is there any reason that you, can think of that it would be safer to remove the fetus in parts than intact?

[p. 40] A None whatsoever.

Q In talking about the procedure in which you removed the fetus intact, let's take the – I think the second example you gave where there is a feet first removal of the fetus.

A Yes.

Q Does that involve, when you say more or less use of instruments than the standard D & E involving fragmentation?

A Less use of instruments.

Q Do you have an opinion about whether that would increase or decrease risk of perforation of the woman's uterus?

MR. SMITH: I'm going to object to that; lack of sufficient foundation that he would have adequate expertise on that he's never performed it, no foundation on any studies or statistical basis for the conclusion.

THE COURT: Overruled. You may answer.

THE WITNESS: I would perhaps start by saying, I would base my opinion partly on the testimony and presentations I've read and heard in meetings of two physicians who describe, in one case, I think something over a thousand procedures, 2,000 procedures, and in the other case, 700 or so procedures with no perforations or major injury prior to 24 weeks. The intact D & E is a recent development. It makes sense to think that doing the steps that these physicians have described would make it easier to evacuate the uterus without as many insertions of the [p. 41] instruments, and that that, theoretically, would be safer. It would be a while before we have the data to compare to say how important that really is, but a series of now probably adds up to 2,700 cases or something less without a major complication except those beyond 24 weeks is a very impressive record for a late abortion procedure.

Q What would be the risk? I'm talking about risks you talked about in the D & E procedure, the one where there is dismemberment? What would be the risk in your opinion of an intact D & E of leaving fetal tissue behind as compared to D & E?

A There would be no risk of leaving fetal – of leaving part of the fetus itself behind because you would see it all intact and recognize whether or not it was complete. With any of these procedures, part of the placenta could be left. That isn't changed by doing the intact D & E procedure, and the placenta is of fetal origin. That's dilating a bit on your question.

Q Could you explain what the significance is of the placenta being of fetal origin?

A Your question had to do with whether there would be fetal remains with D & E, and I wanted to be correct as possible. When conception occurs and the embryo begins to develop, the fertilized embryo very quickly separates into two areas, a central flat disk that is going to develop into [p. 42] the fetus, and the rest is extraembryonic or outside of the embryo but of fetal origin which gives rise to the placenta and the membranes.

Q Does that mean that the placenta has the same genetic material as the fetus in some sense?

A Exactly.

Q Rather than the mother's?

A Exactly.

Q So in either the intact D & E or intact procedure and the D & E involving piece-by-piece removal of the fetus, there is a risk of leaving placental tissue behind?

A Yes.

Q Do you have an opinion about whether in the one procedure you described where the head is coming after the rest of the fetal body and the physician decompresses the head using a scissors or some other instrument, is there a risk, in your opinion, of injuring the mother when the doctor is inserting the sharp instrument into the fetus?

MR. SMITH: Well, he just asked, do you have an opinion. Okay. Go ahead. Sorry.

THE DEFENDANT: Do I have an opinion? Yes.

BY MR. HELLER:

Q What is your opinion?

MR. SMITH: Now I object; no proper and sufficient foundation.

[p. 43] THE COURT: Overruled. You may answer.

THE WITNESS: As I have heard the procedure described, the base of the skull is visible to the operator at the upper end of the cervical canal. It's possible with direct vision to slide the instrument up between the operator's fingers to enter the fetal head. That said, there is no surgical procedure but what somebody can do it wrong, and, you know, I mean, yes, you can injure anybody doing fairly simple things, but it should be a very, very uncommon event.

Q When you talked about induction procedures involving just Prostaglandin, I think you also talked about the saline portions, does it ever happen that that procedure doesn't abort the pregnancy?

A Yes, it does.

Q What happens then?

A Well, back in the old days, we would do a major surgical procedure. We would do an abdominal hysterotomy which is basically a small scale cesarean section, has just as much effect on the woman or more as doing a cesarean section, but we learned over the years that we could do a D & E under those circumstances, that even if

the pregnancy were fairly well along, the cervix by now would be dilated, the fetus would have died and macerated, become soft, and with the technique that we had learned for the D & E, we could safely [p. 44] evacuate those pregnancies and not have to do a major abdominal surgery.

Q Sorry for that diversion. I want to return to intact procedure for a moment. Do you consider the intact D & E procedure, either one, feet first or head first that you've described, do you consider that to be a safe method of doing abortion?

A Yes, I did.

Q Would you use it yourself?

A Yes, I plan to.

Q Can you – Are there situations where you might choose that method in order to preserve a woman's fertility; in other words – Let me be more clear about that. Have you, in instances where a woman's fertility was threatened by a pregnancy, are you familiar with any such cases?

A Yes.

Q Can you describe a situation where that would rise?

A The case that I can describe that I managed last year, not only was the woman's fertility at risk, but her life was at risk.

Q Can you describe that situation?

A This was a patient referred to us who had a rare, awful complication of an amniocentesis done for genetic indications. She had an amniocentesis done outside of our center to diagnose Downs Syndrome for which she was at risk [p. 45] because of advanced age, and in retrospect, we know that the needle went through the intestine of the mother. The patient presented to another hospital about 48 hours after the amniocentesis in advanced infection, very severe infection with a lung disease and kidney disease resulting. She was transferred to our facility, and we were faced with the difficult situation of trying to stabilize this woman with advanced sepsis and then evacuate the uterus which was the source of the infection, and this is the case where I personally did a variation of intact D & E. We, in the intensive care unit, started intravenous Oxytocin to make the uterus contract, put several laminaria tents into the cervix to cause it to dilate, and then about five hours later moved her to the operating room, removed the laminaria, and I was relieved to see the cervix had dilated quite a bit, and the fetal head was presenting. I was able to just put an instrument called a tinaculum which is the sharp end on the fetal head, piercing it, and the brain tissue came out, and the fetus then came out and the placenta came out.

The fetus had died a little bit before that. The mother got somewhat better after our procedure but was still seriously ill the next day, and we determined that her only chance of survival lay in us removing the uterus, so we did extract it the following day. Indeed, there was an abscess, a collection of pus within the wall of the uterus where the [p. 46] needle had entered the uterus, and it had gone through the bowel. The woman did survive.

She was in intensive care unit for six weeks but did survive, so certainly, her fertility was at risk, and she lost it. She ended up losing her uterus. If my initial procedure had been successful, then her fertility would have been saved as well as her life.

Q In that case you've described, did you know – To what degree of certainty do you know that she would die if you hadn't done the procedure?

A Well, I don't. People that – even young people that have ADRS, adult respiratory distress syndrome in response to infection, with expert management of the infection, about half, 60% die. The best we can do, they die. If the infection is not eradicated, probably all would die. First principle, one of the first principles of treating an advanced infection is to eradicate the source of the infection. To fail to evacuate the uterus, I don't know of any survivors in the few cases that I'm aware of where that happened.

Q Could you evacuate the uterus and – Well, I withdraw the question. You have mentioned two other procedures in the course of your testimony. One is abdominal, I think abdominal hysterotomy. The other was hysterectomy?

A Correct.

Q Are those procedures used to terminate pregnancies?

[p. 47] A Formerly, yes, but with the careful work of the Centers for Disease Control, the branch of our government, studies of legal abortion were performed

through the 1970s and early 80s, and these studies demonstrated that the risk of serious complications and death from these major surgical procedures, hysterotomy or hysterectomy, far, far exceeded the risk of death to the mother from doing the other abortion techniques, the vacuum curettage or D & E or saline or other labor – induction methods. That the risk to the mother was many-fold greater from major surgical procedure. Consequently, those procedures have pretty well died out. They are only used to provide abortions. They are only used in exceptional circumstances.

Q What would be an example of an exceptional circumstance?

A Oh, I quite frankly can't think of one that I would not manage in another way, but it is accepted that, for example, if someone with an extensive premalignant lesion of the cervix, extensive carcinoma in situ of the cervix where you know surgery is going to be indicated, and the woman has an advanced pregnancy, that it is acceptable just to move right to the hysterectomy and take care of both things at the same time.

MR. HELLER: I want to show you – If I may approach the witness?

THE COURT: You may.

[p. 48] BY MR. HELLER:

Q – exhibit 24 which has been received into evidence.

THE COURT: May I have Exhibit 24, please? No, no. Is there a copy for me?

MR. HELLER: I don't know if there is.

THE COURT: That's all right. Go ahead. Don't worry about it.

THE COURT: Mr. Smith, do you need that?

MR. SMITH: I'm sufficiently familiar with it that you can have it.

THE COURT: All right. Thanks. Thank you.

BY MR. HELLER:

Q Dr. Stubblefield, have you seen that document before?

A Yes, I have.

Q Can you identify it, please?

A It's a statement of policy issued by the executive board of the American College of Obstetricians and Gynecologists.

Q Does that statement describe abortion procedure?

A Yes.

Q Is it your – Does that – Have you described that procedure today?

A Yes.

Q What would you call the procedure that is described in this statement?

A It's one of the two variations of intact D & E.

[p. 49] Q If you turn to the second page of that exhibit, would you, just to yourself, read that paragraph?

Do you agree with that document's statement that the procedure described in it may be appropriate, may be the most appropriate procedure for some cases?

A Yes.

Q Do you know what the status is of a document like this from the American College of Obstetricians and Gynecologists? What is the meaning of this type of statement?

MR. SMITH: Just for clearness, are you talking the policy in its entirety?

MR. HELLER: Well, let me be more clear with that question.

BY MR. HELLER:

Q Do you know if this type of document has any particular status within ACOG's heirarchy?

A Well, in general, Fellows who make up the organization are guided by such policy statements. They are never meant to supersede the judgment of individual physician, and the ones that are labeled as practice guidelines always bear a disclaimer at the bottom that says exactly that, that they are not meant to establish a medical-legal standard or to be the only thing that someone can do. I don't remember the wording, but they certainly are a guide to practice.

Q I want to talk to you a little bit and ask you some [p. 50] questions about circumstances under which women obtain later abortions. Let me start by saying something like, Doctor, 16 weeks, can you describe some

of the circumstances that would lead a woman to request an abortion after 16 weeks of pregnancy?

A Well, there is a wide range. I think the most common association with later abortion is youthfulness. The young woman who is herself physically well and does not have an abnormal pregnancy, but it is for her one that she does not wish to continue for any of a list of reasons, but because she is young, she delays in admitting that she has a problem. She delays in seeking help. In many states there are barriers that make it legally difficult for her to obtain that help and ends up into mid pregnancy before she is able to reach a provider who will provide abortion for her. There is a range of other circumstances that I've seen over the years. Women who are finally deciding to leave their abusive spouse who has beaten them one more time, and this was the one time they just couldn't put up with any longer. Spouses abandoned when a pregnancy, quite frequently, in my perspective, women may develop a serious disease or one may get worse in the pregnancy. The patient may not have even known that she had the disease before until she becomes pregnant, and when you add changes of pregnancy now, the disease becomes manifest, and she has reached a [p. 51] decision whether she will take the risk of continuing the pregnancy or terminate it. Fetal malformations is another one that we deal with not infrequently, the most common of those being Downs Syndrome, but there are a whole long list of others that can now be diagnosed through the advances of science and diagnosis. There are a long list of conditions that are very, very serious, life threatening, that will seriously affect the quality of life of a fetus should it survive and be born,

and where parents are given the opportunity, may choose to abort or may choose to continue the pregnancy.

Q Have you ever had a request from another medical professional for an intact fetus after an abortion?

A Yes, I have.

Q What are the circumstances of that, sir?

A The circumstances are, this latter group of cases I described where a fetal malformation has been diagnosed and the geneticist or internal medicine specialist who has made the diagnosis wants an intact fetus so that it's easy for the pathologist to examine the fetus and confirm the diagnosis. In the past, not knowing about the D & E procedure, I have generally declined to honor that request feeling that in my hands, the D & E procedure was safer and easier on the woman than going through labor induction. Now that this new technique is available, were I in this circumstance now, I [p. 52] think I would try to provide the intact D & E.

Q In talking about D & E's versus induction abortions, are there any situations in which an induction abortion is dangerous for a woman or not contraindicated for a particular individual?

A Well, there are certain circumstances where there isn't any real good way out, but, for example, with a woman whose fetus has severe hydrocephalus or water on the brain, when the head is tremendously distended and swollen, to induce labor isn't really going to work. The woman is not going to be able to expel that fetus until the fetus dies and the head begins to be depressed unless you decompress the head yourself.

Q Are there any health conditions where you wouldn't want to administer the particular drugs that are necessary for the induction like Prostaglandin?

A Yes, there are. There are a variety of circumstances, women with severe heart disease, for example, where the labor itself or the drugs could be a problem. The Prostaglandins that we have typically used, Prostaglandin E2 and Prostaglandin F2 Alpha have significant cardiovascular effects, and the woman who already is, for example, in heart failure, it would be somewhat frightening to use them. There is a newer Prostaglandin. This is a bit of a technical discussion, E1, which is Misoprostol which may well be safer. [p. 53] We don't have any experience with it yet, and women with these kinds of problems, but to do an D & E avoiding those medications, the D & E can be done without major anesthetic. It can be done fairly easily with what we call conscious sedation which are low doses of a sedative and pain relieving medications which are really quite safe, given intravenously. One could be a D & E or intact D & E in most of these circumstances and avoid using those drugs and be of benefit to the woman.

Q Dr. Stubblefield, I want to read to you now the definition of partial-birth abortion in the Nebraska statute that is at issue in this case. The statute says, "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living, unborn child, before killing the unborn child and completing the delivery." The statute then goes on a little bit further. "For purposes of this subdivision, the term partially delivers vaginally a living, unborn child, before killing the unborn child means deliberately

and intentionally delivering into the vagina a living, unborn child, or a substantial portion thereof for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child." Now, I want to start with some of these terms and ask you if you have an understanding of them.

[p. 54] THE COURT: Counsel, before you do, it's about 10:25. Give me a sense of how much longer you'll be with this witness.

MR. HELLER: I think at most 20 minutes, Your Honor.

THE COURT: All right. Let's take our mid morning break now, if you don't mind.

MR. HELLER: No, no.

THE COURT: We'll come back in 15 minutes, and we'll conclude this witness's testimony at that time. We stand in recess. Let me see counsel at the bench, please. Sir, you may step down. (Recess from 10:25 to 10:40 a.m.; all parties present)

THE COURT: You may proceed.

BY MR. HELLER:

Q Thank you, Your Honor. Dr. Stubblefield, before the break I had just read to you a definition from the Nebraska statute of partial-birth abortion. I want to ask you some questions about that definition. First, is the term partial-birth abortion a term you've encountered in medical textbooks or articles?

A No.

Q The next part of the definition I want to ask you about is the phrase partially delivers vaginally. Can you describe what your understanding is of delivers vaginally?

[p. 55] A Well, in the case of delivering a baby at term, a vaginal delivery refers to helping the baby come out of the mother. I'm guessing that the legislators had something like that in mind. To deliver means to present, put in front of you.There is no medical meaning to these. These are words that a nonmedical person has made up. I presume they mean pull a piece of the fetus down into the vagina and out of the vagina.

Q The definition says that partially delivers vaginally a living, unborn child, means deliberately and intentionally delivering into the vagina a living, unborn child, or a substantial portion thereof. It goes on, but I want to ask you some questions about that. What would it mean to deliver into the vagina a living, unborn child, in your view?

A Pull, pull the fetus down into the vagina.

Q So from your prior testimony, do I understand correctly, that means taking the fetus from within the uterus and through the cervix into the vagina?

A Yes.

Q It doesn't necessarily mean out of the woman's body completely?

A You're right. It doesn't say that, correct.

Q Now, then, the statute also talks about deliberately and intentionally delivering into the vagina a substantial portion of a living, unborn child. What is your [p. 56] understanding of what would constitute a substantial portion of a living, unborn child?

A Subject to opinion. There is no legal or medical definition of what constitutes a substantial portion of an unborn child.

Q The statute then goes on to say that all of this has to be done for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child. I want to ask you, in which types of abortion procedures does the physician know that the procedure will kill the unborn child?

A All of the surgical abortion procedures, vacuum curettage, all variations of a D & E.

Q What about a first trimester procedure?

A Yes.

Q Are there types of abortion procedures that do not involve delivery into the vagina of a living, unborn child, or a substantial portion thereof?

A Well, the only thing that I can – The only way I can think of to avoid that, there are two ways. One would be to always do an abdominal operation so that nothing is delivered into the vagina, or do something that will cause fetal demise prior to the abortion procedure in every case.

Q So in the first case, you're saying that it would be to avoid the law because it's not through the vagina. It's [p. 57] through the abdomen?

A Correct.

Q That the fetus is delivered. What procedures – what are the procedures you can do abdominally?

A Hysterotomy and hysterectomy.

Q Those are the procedures you testified to earlier are significantly riskier for women?

A Definitely.

Q The alternative of fetal death or fetal demise, I take it, you think that avoids the statute because they are – you're not delivering the unborn child?

A Correct.

Q How would you – How would one bring about fetal death prior to getting an abortion procedure?

A Amniocentesis and attempt to inject into the fetus a substance such as potassium chloride or Digoxin to stop the heart of the fetus.

Q Are there any risks that you're aware of in performing such an injection into the fetus?

A Yes, there are.

Q What would those risks be?

A One of them is just the passing of the needle, as the case that I just described illustrates. Rarely, but for real, the needle may traverse the bowel which is full of

bacteria and then carry those bacteria into the uterus where [p. 58] they are protected from the body's immune system and can cause rapidly progressing infection. One could also spear a blood vessel and cause significant bleeding with amniocentesis. The substances themselves seem to be harmless if they are injected into the fetus, but if they were inappropriately injected and enter the mother's bloodstream, they could be dangerous to her.

Q Are there any benefits to causing fetal death by such an injection?

A Those kinds of procedures are done typically after 20 weeks, and there is an advantage at that point on in allowing an easier evacuation procedure.

Q How does that work? Why is it easier?

A If one does this, one variation of a D & E is to use laminaria over two or three days, and at the start of the procedure to do an amniocentesis, inject Digoxin or potassium chloride into the fetus to produce fetal death, then not perform the actual abortion for another couple of days, so during that time there is time for the fetal body to begin to decompose and soften so it will be easier to remove with the instruments. That is done, not uncommonly, after 20 weeks. To try to do it at eight weeks would be ridiculous. It would be hard to do, take great skill to do it. You couldn't do it predictably without injuring the mother.

Q Do I understand you then to say that the risks to the [p. 59] mother increase, the smaller the fetus is, the earlier the pregnancy is?

A If you you [sic] are trying to insert the needle through the abdominal wall of the mother and avoid injuring her, yes.

Q No benefit?

A No benefit, no benefit except to the doctor going to jail and losing your license and livelihood.

Q Now, if the Nebraska definition that I described to you were in effect in Massachusetts where you practice, what effect would that have on your practice? What would – How might it change your practice?

A I think we would probably have to stop providing this service until the courts clarified what exactly is meant medically by these words.

Q Now, I want you to assume for the moment that the Court clarifies these words which you've indicated could apply to any abortion other than an abdominal one or one where there is fetal demise. Suppose the Court clarified those words to say that all this prohibits is just an intact D & E either with feet first or head first, one of those procedures, but it prohibits both of those. What effect would that type of prohibition have on your practice?

MR. SMITH: Just going to interpose a *foundational* objection. I don't think it's relevant. It's speculation, assuming what the Court would do.

[p. 60] THE COURT: Overruled. You may answer.

THE WITNESS: My service is presently not going beyond 20 weeks. Again, if you want a long

answer, I can tell you what I have been thinking about as director of the service. Presently, between 16 and 20 weeks, we hospitalize the patient for a labor induction abortion with Prostaglandin. We stop our D & E's at 16 weeks. I have been planning, now that I have hired new staff in the last few months, to try to extend our D & E's to 20 weeks and stop doing the hospital ones. Part of that is a cost saving measure, expends a lot of hospital resources, many thousands of dollars to care for a patient in the hospital, and for patient convenience does not have to be admitted to the hospital. Patients don't like that, so I have been actively thinking that we would try to adopt some variation of intact D & E in order to make it easier on ourselves, our patients, and our residents to provide D & E in that range, the 16- to 20-week range. Obviously, if this law works and exists in its present form in Massachusetts, we would not be able to do that.

BY MR. HELLER:

Q Why would you, in making a transition from your current practice in your abortion service to a new way of doing abortions from 16 to 20 weeks, why would you choose an intact D & E procedure?

[p. 61] A Because as it has been described to me, it sounds like it would be easier consistently to do, easier for the patient and easier for the physician, and if I add this procedure, I would be dealing with trainees, residents in training, who want to have something that is safe and easy for them to consistently perform. Also, I would like other physicians to be able to do it. You know, selfishly, myself, I don't want – I would like to make the

commitment to the patients that we'll provide this service. I don't want to tie me up all the time doing it. I would like other people – I know I can do these by standard D & E. I have done it for years. I would like a simpler, easier technique.

Q And you've testified earlier that your opinion was that there might be less risk of perforation and less risk of fetal tissue left behind with the intact procedure. Are those the reasons you believe it might be safer for women to have that procedure?

A Those, plus I believe that there should be less likelihood of the rare but devastating complications of the blood clotting abnormality, the DIC and the still less common amniotic fluid embolism.

Q Why would you think those rare complications might be less?

A Because I believe that they relate to fetal tissue entering the mother's circulation during the performance of [p. 62] the abortion. If there are less manipulations within the uterus, less fetal tissue within the uterus less, specifically brain tissue within the uterus that enter the mother's circulation, less risk of those complications.

Q Going back to the – Let's assume there is no court interpretation of the statute. You're just going on what you understand the words to mean. Is there some – Well, suppose someone were to say that substantial portion in the statute means more than a little bit of the fetus. What would you understand that to mean?

A It sounds like they would be precluding most surgical abortions, making it illegal.

Q I just have a couple more questions, and I think I will be done. Do you have any reason to believe that the intact D & E procedure is less safe than the standard D & E procedure involving removal of the fetus in parts?

A No.

Q Do you have any reason to believe that the intact D & E procedure is less safe than an induction procedure using Prostaglandin or other drugs to induce delivery?

A At equal gestational ages?

Q Yes.

A No, I do not.

Q Would you have any hesitation using intact D & E procedure to remove a dead fetus?

[p. 63] A No, I would not. I would not hesitate to use it.

Q One other thing you testified about earlier, I wanted to clarify. You talked about situations where the head of the fetus would have to be compressed or made smaller. Why couldn't one just pull the head out without compressing it in either a D & E or an intact D & E?

A Because of the resistance of the cervix. The cervix is only minimally dilated. The cervix is not dilated as much as the head is.

Q Are there other parts of the fetus that are also too large to pull out through the cervix?

A The diameter at the hips is almost but not quite as great, and that typically will come through if – It's

kind of a physics motion problem, but if the – if you will, the body is tapered either way, and if you are – That does not turn out to be a problem.

Q Is there any reason you just don't dilate the woman's cervix more until the entire head can come out?

A It takes quite a bit more time to do that, and during that time, there begins to be risk for infection. There is – you're delaying the process, still further risk for bleeding. Just not practical to do it.

Q How is the fetal head removed in an ordinary D & E that is not intact? How does the head get removed?

A You crush it with the forceps and then remove it.

[p. 64] Q In a standard D & E where you crush the head or you have removed other parts, are there – Is there any meaningful difference between crushing the head and removing the contents with a through suction?

A No, there isn't.

Q Is there any risk in a standard D & E from, in later pregnancy, from bones of the fetus or sharp parts of the fetus?

A Yes. With the more advanced gestations, as you're trying to crush and pull out the skull or long bones, one, you can lacerate the cervix with those fetal parts as you're pulling out.

Q Would that risk be the same with the intact D & E?

A No, it would be less.

MR. HELLER: No further questions, Your Honor.

THE COURT: You may inquire.

CROSS-EXAMINATION

BY MR. SMITH:

Q Thank you, Your Honor. Dr. Stubblefield, just some questions that at least weren't clear to me as far as your actual abortion experience. As I understood your testimony, is that you supervise in some supervisory capacity 1,500 to 2,000 abortions a year at present?

A That's correct. They are performed on my service.

Q Okay. Now, supervision can be direct where you're [p. 65] actually present, or indirect where you are not even, frankly, on the premises. What are the numbers of abortions where you are either performing them yourself or are there directly supervising?

A That is, as I said, I cover our little abortion unit, I think I said once or twice a month, and we will typically perform eight or 10 procedures, in that range, at each of those sessions. The way it's organized, the attending, which would be me in that case, turns up at 8:00 o'clock, and we'll begin. Residents are finishing rounds up on labor and delivery, so I will do two or three procedures myself, and then the resident appears around 9:00 o'clock, and the rest of them are done by the resident with me coaching them. I whisper in their ears, and if they are getting into difficulties, then I take over get them by the difficulty and guide them through the procedure.

Q So it would be accurate that you either perform or directly supervise the performance of approximately eight to 10 abortions per month at the present time?

A Depending on the month, might be 20, might be 10.

Q And that has been the case for approximately how long?

A Three years.

Q A couple of questions about the American College of Obstetricians and Gynecologists. I believe you said you had to be board certified to be admitted to ACOG?

[p. 66] A To be a Fellow, yes. You can be a junior Fellow after you finish training before you pass the boards.

Q And you said you are a member. Do you mean by member you are a Fellow?

A I'm a Fellow.

Q And the board certification that is necessary to be admitted to ACOG comes from where?

A From the American Board of Obstetrics and Gynecologists.

Q And is that a specialty organization affiliated with the American Medical Association?

A Yes. For each of the disciplines there is a licensing board that operate under an umbrella organization called, I think, the ACGME, the Accreditation Counsel and Graduate Medical Education.

Q When you say discipline, you mean a medical specialty?

A Yes.

Q And to become board certified, I take it, you would have had to have passed some type of certifying examination?

A Yes. To be eligible for the board, you've got to have completed the four years of post-graduate training after medical school in the residency that's approved by yet another organization called the Accreditation Council for – well, a different outfit under the ACGME. You have to graduate from the the [sic] approved residency in good standing. You then take a written exam the summer after finishing the [p. 67] residency. If you pass that written exam, you're then, you enter a sort of a probationary period where you practice as a specialist. You collect your cases, you submit your case list of every patient you've delivered or every surgery that you've done to the board, and if they agree that you've done a sufficient number, then you're allowed to sit for the oral exam which is – typically occurs about two years after you've completed residency training in the usual sequence.

Q And physicians who are board certified in obstetrics and gynecology, what's the criteria for them to go the next step to become Fellows or members of the American College of Obstetricians and Gynecologists?

A The process involves filling out some forms, documenting your education and board status, and getting two local Fellows in the community to propose and

endorse you, and then these papers are all reviewed, and you're admitted or not admitted.

Q So it would be an accurate statement that not all board-certified physicians are ACOG members, correct?

A That's correct, although the vast majority are.

Q Now, the various abortion procedures that you testified to, would you describe all of them as surgical procedures with the exception of the pharmaceutical abortions?

A Yes.

Q And the pharmaceutical abortions would be the RU 486, [p. 68] the Methotrexate?

A Correct, and the labor induction abortions are also pharmaceutical abortions performed later in pregnancy with the Prostaglandins.

Q When you were describing the vacuum curettage method of abortion, at least my note was, you referred to the fetus living outside the uterus while in the cannula. At least that can happen?

A Yes.

Q What did you mean by the fetus living?

A Well, I mean, the heart could still be beating for a period of time.

Q So would your definition of a fetus living being a fetus heartbeat?

A That's the best one I can come up with, yes, sir.

Q Is that generally recognized by the medical profession?

A To my knowledge, there are no expert committee statements on that issue.

Q At least your peers or those that perform abortion, do you know if a fetus living, fetal heartbeat is synonymous with a living fetus?

A If it's intrauterine gestation, then it certainly is accepted, the fetus heart as beating is living.

Q If there is, no fetal heartbeat?

A The question you're describing –

[p. 69] Q Go ahead.

A I was going to say where we have an abortion in process and pieces of the fetus coming out, no one, to my knowledge, has tried to formally address what is living or not living in that context.

Q Now, you gave some various statistical rates in your testimony as far as risk of death in abortion. I had one in a hundred thousand risk of death from abortion versus childbirth. Where did you come up with those statistics?

A Probably the most succinct way to answer that question is to refer to the American Medical Association report which I believe has been placed in evidence. That report summarizes in one place two bodies of data, publications from the Centers for Disease Control, the government agency in Atlanta, and annual surveys by the Alan Guttmacher Institute in New York City which also tracks numbers of abortions.

Q If I could approach the witness, Your Honor.

THE COURT: Yeah. Counsel, for your information that also is reprinted in our previous opinion and described, at least, planning effect 64, I believe.

MR. SMITH: My purpose is just to make sure that this [sic] what we understand in this witness's – what his basis is, what he's relying upon.

THE COURT: Sure. Go ahead.

BY MR. SMITH:

[p. 70] Q Doctor, showing you Exhibit 6, would that be the portion of the AMA report containing the statistical data you relied upon for risk of maternal death?

A Yes.

Q That's from abortion?

A Correct.

Q Now, in your testimony when you were talking about an intact D & E, you used the term recent development. How recent of a development?

A I believe 1995 is the year that Dr. McMahon made a presentation at the meeting of the National Abortion Federation, April of that year, I believe. There is Dr. Haskell who made a presentation. I'm not sure whether it was in the same year or a subsequent year.

Q And during your testimony on direct, you referred to presentations at meetings, medical papers. Would that be presentations by Dr. McMahon and Dr. Haskell?

A I'm not exactly sure what you're referring to.

Q Okay.

A In my testimony.

Q Okay. In reference to your knowledge of the intact D & E procedure, you referred to some paper presentations at meetings. I'm just trying to understand who made the presentations.

A McMahon and Haskell.

[p. 71] Q And as far as the credentials for Dr. McMahon and Dr. Haskell, do you know if Dr. McMahon is board certified?

A I do not know.

Q Do you know if Dr. Haskell is board certified?

A I think Dr. Haskell, if I'm not mistaken, is a family physician, and whether or not he is board certified in that, I do not know.

Q And the presentations, were they actually physically present when they made their presentations?

A Yes.

Q The presentations were made at what organization?

A National Abortion Federation.

Q And these presentations, would these have been presenting papers?

A Yes.

Q Okay. And also oral presentation?

A They were oral presentations.

Q And prior to that time, as far as your knowledge or awareness of the intact D & E abortion procedures that were described in their presentations, did you have any knowledge of such a procedure?

A No, I did not.

MR. SMITH: I'm looking for Exhibit 24 is what I'm looking for.

THE COURT: Is 24 the –

[p. 72] MR. SMITH: It's the policy statement.

THE COURT: You have your copy.

MR. SMITH: I don't need my copy. I wanted to have the one for the witness. If I could approach the witness?

THE COURT: You may.

BY MR. SMITH:

Q Dr. Stubblefield, showing you what is marked as Exhibit 25, the ACOG policy statement, that statement refers to an abortion procedure described as an intact dilatation and extraction procedure, correct?

A Correct.

MR. HELLER: May I just note, I think it's Exhibit 24, just to be clear.

MR. SMITH: I meant 24. Okay.

BY MR. SMITH:

Q Exhibit 24 is the ACOG policy statement, correct?

A Correct.

Q And it refers to the intact dilatation and extraction procedure?

A Correct.

Q And also uses the terminology for abbreviation intact D & X?

A Correct.

Q Now, the intact D & X, would that be the same procedure which you've previously testified to as the intact D & E [p. 73] procedure?

A It's one of them.

Q And how would the intact D & X procedure vary from the intact D & E which you previously testified to?

A It's really a technical point. Dr. McMahon described two variations of procedure depending on how the fetus presents, whether it's presenting head first or feet first. This describes just the version where the fetus is either presenting feet first or one is able to convert it into a feet first presentation by reaching up and pulling down the feet.

Q When you say this describes, you are talking about Exhibit 25, Exhibit 24?

A Correct.

Q So at least as far as the understanding of an intact D & X, that would be the procedure in which you were

doing an abortion in a breech manner or converting to do an abortion in a breech manner?

A It's not exclusively that. There are two procedures that are described. ACOG dealt with just one of them.

Q Okay. Well, ACOG calls the procedure an intact D & X, is that correct?

A This is true.

Q And as far, as just understanding terminology, if we are using intact D & X, that would refer to the ACOG description, [p. 74] Exhibit 24?

A But not exclusively.

Q Does ACOG have any other definition for intact D & X than appears –

A No.

Q Now, the intact D & X procedure, to your knowledge, does that appear in any medical text or peer-reviewed medical journals?

A I have added it to a chapter that I regularly write and revise, and Dr. Nichols's Textbook of Gynecologic Surgery that is in press now. It's not yet been published.

Q Prior to the AGOG policy statement in January of 1997, was the intact D & X procedure described in any medical journals or medical texts to your knowledge?

A Not to my knowledge.

Q The fact that the ACOG policy statement describes the intact D & X procedure, does that mean that

the procedure as described is generally recognized in the medical profession, not accepted, just recognized that it exists?

A I'm not – I'm not quite sure what the technical meaning of generally recognized is. The purpose of ACOG writing this was to clarify an area that was not generally known.

Q Essentially establish the policy, correct?

A Yes.

Q Now, have you ever performed an intact D & X procedure?

[p. 75] A As defined, option B as defined in the AGOG statute, feet first?

Q That's correct.

A I have not.

Q Have you ever seen it performed?

A No.

Q Are you aware of any peer-reviewed medical articles which compare the safety of the intact D & X abortion procedure as opposed to other abortion procedures?

A No.

Q Are you aware of any medical studies which compare the safety of the intact D & X abortion procedure versus other abortion procedures?

A No.

Q Do you know of any reason why there are no such studies comparing the safety of the intact D & X versus other abortion procedures?

A There are several reasons for that. Primarily, it's the novelty that this is something new. This is what happens in every area of practice. There is nothing that starts out with a large randomized trial. You can't do that until you have someone start with a pilot study where they do their procedure and perfect their procedure to the point where it's useful, and it's only appropriate at that time to try and compare it to something new. Also, there is essentially no [p. 76] funding for this kind of research.

Q Now, you testified – If I'm putting words in your mouth just correct me – but as I understand it, there are studies under way for other pharmaceutical drugs, abortion drugs?

A That's correct.

Q And the purpose for the studies, as you understand it, would be what?

A I was probably referring to use of Tomoxifen for early abortion.

Q Well, let me just ask you, there is a drug known as Amoxifen?

A Tomoxifen.

Q Tomoxifen?

A Um-hm.

Q That's a drug that's purported purpose is what?

A It would do the same thing that the RU 486 drug does but in a different way, namely, hormonally affect the pregnancy so that it will then be expelled in response to the low dose of Prostaglandin in early pregnancy.

Q And the type of studies that you're describing that are under way, what do you mean by study?

A I mean that a protocol – I mean, a single investigator in that case, Dr. Michelle, came up with the idea, presented it, wrote it out, presented it to his institutional review board that rules on the permissibility of human studies and [p. 77] carried out, treated a number of patients with the new medication in early pregnancy, carefully observed the outcome and presented it to peers, and in response to his promising findings and his pilot study, a larger national study was planned funded by the Planned Parenthood organization and is, I believe, being currently carried out in a number of centers following Dr. Michelle's protocol.

Q Would the purpose of the study be to demonstrate the safety and effectiveness of the drug?

A Yes.

Q In other words, turn it from theory to proving it as medically-accepted fact?

A Yes.

Q And has the safety of the intact D & X procedure ever been studied to the point that it has been medically-accepted fact that it is a safer abortion procedure?

A All we have thus far are the two reports from two doctors that we have mentioned who have given brief accounts of their experiences.

Q Would the answer to my question be no?

A Yes.

Q So there have been no studies yet which have confirmed that the intact D & X procedure is, in fact, a safer abortion procedure than other abortion procedures?

A Correct.

[p. 78] Q Do you believe that is necessary?

A I think it would be appropriate to do it. I think that when one has discovered a way of doing something that is so much easier than what you're already doing, that it's kind of questionable whether you really need to go to that extent. If you are struggling to open the door to a car, and I can show you how to put the key in the lock and then the door opens easily, we don't need a randomized placebo-controlled trial to show the keys are important.

Q But as far as the practice of medicine, doesn't medicine proceed on the basis that something becomes medically accepted only once it has been tested, proven, and generally recognized by the medical community?

A In the case of surgical procedures, it's not quite that orderly. Things tend to move in leaps and bounds. Sometimes surgical procedures are evaluated on a randomized basis. It would be nice to do that, but more frequently, they are not. Open heart surgery was not tested in a randomized, controlled way. People figured

out how to do it. Patients lived, they kept doing it, got better at it.

Q Would you agree that abortion surgical procedures as performed in this country, at least as you understand how they are performed, is one of the safest surgical procedures in the country?

A Yes.

[p. 79] Q And would that be the case excluding the intact D & X abortion procedure?

A I'm not quite sure where you're going with this, but the vast majority of abortions are done in first trimester, 90-some percent. The D & X procedure is not needed in the first trimester. The benefit to patients from having this procedure would fall, would be available for a smaller number of patients, basically those who undergo the procedure after 16 weeks which is something like 5% of the abortions that are done.

Q Well, the intact D & X procedure as defined by ACOG and your understanding of the D & X procedure as presented at the '95 papers presentations, prior to that time, abortions were performed in other manners in a safe manner, weren't they?

A It's not a question of relativity. By that, I mean, safe compared to what? The labor induction abortion with saline were safer than major surgery, but it were not as safe as standard D & E or as some of the Prostaglandin methods that have come along since.

Q Now, can you describe to us what your supervisory and also your direct supervisory involvement would be with medical residents?

A With –

Q I'm trying to understand your responsibilities. As I understood, you overall supervise a program which will have [p. 80] approximately 19 to 25 residents in it at one time?

A Um-hm. Sure. I'm the chairman of the department, so the responsibility, a lot of things, it is my responsibility to ensure that a variety of programs are carried out. I'm responsible for the Dean for the medical students, I'm responsible to the president of the hospital from the overall conduct of the service, but obviously, I cannot and do not do everything myself. I hire people. I try and hire the best people that I can, talk to them, look at their results, and coach them and fire them if they don't do a good job.

Q Do you have responsibility for determining what the residents are taught?

A Yes, within guidelines provided by the residency review committee in obstetrics and gynecology.

Q And do the residents at Boston University, are they presently taught the D & X procedure?

A Let me just clarify. The residents aren't at Boston University. They are at the hospital.

Q Okay.

A And they are presently not taught the D & X procedure.

Q And have the residents in your tenure with your supervisory role in the residency program, have they ever been taught the D & X abortion procedure?

A No, not yet at our institution.

Q Are they taught other abortion procedures?

[p. 81] A Yes, they have been taught standard D & E. The present residents are doing them all the way up to 16 weeks with D & E.

Q Are there any current proposals to teach the D & X abortion procedure to the residents?

A Yes.

Q And have those been accepted for approval?

A Well, I'm the one that does the approval. It's just a case of really making sure that I have the right people and the right place to make the change, and I hired a key person who started work in October, and that's our next project once we get a few other things finished.

Q Now, the partial birth abortion bill that Nebraska has, does Massachusetts have such a bill or similar bill?

A They have a similar bill, but it's different in a very important way. It does not apply until after 24 weeks of gestation, so it does not affect any previability abortion.

Q And are you generally familiar with what OBGYN residency programs in the country, what they are teaching the residents?

A Generally.

Q Are you aware of any OBGYN which is teaching the D & X abortion procedure?

A No.

Q And just to understand the residents of OBGYN programs, [p. 82] those are the physicians that are being taught the specialty for future practice?

A Correct.

Q And the purpose of a residency program would be to keep the residents up-to-date and current so they can go out and properly treat people?

A Yes.

Q I think you said this, but just my memory, to make sure I asked you, it is possible to determine whether a fetus is alive or dead before you begin an abortion procedure?

A Yes.

Q And what are the mechanisms? How you would make that determination?

A The most important one would be ultrasound.

Q And would you expect that any competent physician should be able to make that determination whether the fetus is alive or dead before performing an abortion?

A If that person has had some training in performing ultrasounds.

Q And that gets me to a question, I wasn't clear on what you said on direct. Does the physician typically, when performing an abortion, have ultrasound monitoring of the mother during the entire procedure?

A First trimester, it is very rarely used. Beyond first trimester, different physicians begin to use it in different [p. 83] gestational ages.

Q And the purpose for using it would be what?

A People, especially people who are beginning to learn the procedure, appear to be helped to guide the instruments properly by being able to visualize structures inside the uterus, especially with standard D & E when the head is the last thing removed. The uterus has started to contract, it can be difficult to locate, and the inexperienced operator might injure the uterus, whereas with ultrasound, they can see exactly where it is. With experience, one learns to feel, and there is less need for the ultrasound.

Q Would it be an accurate statement that a physician can use the ultrasound throughout the entire abortion procedure?

A That would be accurate, yes.

Q And whether or not one, one being a physician, actually uses the ultrasound throughout the entire procedure primarily depends upon the level of expertise of the physician?

A It's a trade off. The ultrasound machine is expensive. Cheapest ones are 30 or $35,000. It becomes less worthwhile to visualize as the procedure progresses. Once the amniotic fluid is gone, you don't see as well. Once the uterus starts to contract and parts are removed, you can see things less clearly with the ultrasound, so that there is variation in terms of what operators choose to do, but there are limits as to what you can see with it.

[p. 84] Q As far as the medical standard of care in this country, would it be the medical standard of care of

this country that a physician performing an abortion should always have an ultrasound to assist him?

A Should always have an ultrasound?

Q Yes.

A Not yet.

Q And are there, just trying to understand abortion procedures in which you would not be the standard of care to use an abortion procedure, are you talking about the first trimester or the entire term?

A First trimester, there is really no benefit to trying to use it to guide you during the procedure. It's helpful to have obtained one preop, but again, there is a trade off. Most abortions are paid for by the patient themselves. The charge in most hospitals or ultrasound labs for doing ultrasound considerably exceeds what abortion clinics charge for the abortion. Abortion clinics typically charge $350. An ultrasound in a hospital is 300, $350 for the radiologist, $200 for the hospital, 500 bucks, so that to insist that an ultrasound always be done is to considerably increase the cost.

Q I guess my question is, as far as the standard of care of using an ultrasound, is it – is the standard of care that an ultrasound would be used during the second and later [p. 85] trimester?

A No.

Q And by use, I'm talking about having an ultrasound examination at all.

A Well, that's different.

Q Okay. That's –

A I think – I'm not sure it's an absolute requirement, but I think that prudent physicians will generally have a preop ultrasound at some point in the early mid trimester, 13, 14, 15 weeks.

Q So reasonable –

A It's prudent to do an ultrasound.

Q A reasonably prudent physician would have an ultrasound done?

A Yes.

Q You're not a pathologist, are you?

A No.

Q Is there a subspecialty of pathology known as fetal pathology?

A I don't think there is any board certification. There are certainly individuals who spend more time studying the fetus, the placenta, pregnancy, complications.

Q Would you agree that a pathologist who performs pathologies on fetuses would be better qualified to know what he needs than you would?

[p. 86] A In terms of?

Q What he needs in order to do a proper fetal autopsy.

A Yes.

Q Would you agree that an abortion procedure is safer than a shot of penicillin?

A First trimester, clearly.

Q And do you recall that you testified in the state of Arkansas?

A Yes.

Q And do you recall this question and your giving this answer, or these questions and your giving these answers? "Is it your opinion that abortion is one of the safest surgical procedures in the United States that exists?" Answer you gave was, "Yes." Question: "Would it be even more safe than a shot of penicillin?" Answer: "Yes, it would. Approximately one in a hundred thousand patients who receive penicillin die of anaphalaxis, severe allergic reaction to penicillin."

A Yes.

Q Do you agree with those questions and answers that you gave then?

A Yes, I do.

MR. SMITH: Nothing further.

THE COURT: Redirect?

MR. HELLER: Very briefly, Your Honor.

[p. 87] REDIRECT EXAMINATION

BY MR. HELLER:

Q I want to ask you some questions to clarify some of the questions that Mr. Smith asked you. You testified a couple of times about your service at your hospital. Can you just tell the Court what you mean by the service, the service that you run?

A Well, you mean –

THE COURT: Counsel, if it makes any difference, I know what service means, but if you want to make a record, go ahead.

BY MR. HELLER:

Q If you could just briefly state –

A Do you mean our entire operation, or you mean just the abortion service.

Q The abortion service?

A Just the abortion service. We have two facilities. We have inpatient beds where we provide the labor-induction procedures, and we have really very much a small abortion clinic within our larger ambulatory care facility where we provide prenatal care, gynecological care, and we have two treatments rooms and two exam rooms, and a dedicated nursing staff where we actually perform the abortion procedures.

Q You also testified that you were not currently teaching the intact D & X method of abortion as described in Exhibit [p. 88] 24 to your residents?

A That's correct.

Q Do you teach the Methotrexate method of abortion to your residents?

A No.

Q Do you teach the RU 486 method to your residents?

A No, not yet.

Q You also testified a little bit about the difference between how surgery evolves. Do you know, does the FDA, the Food and Drug Administration require, if you know, a formal approval for new surgical techniques?

A No.

Q Do they require that for new drugs?

A Yes.

Q Is that part of the reason that drugs are studied perhaps more carefully or more formally than surgery, new drugs?

A Yes.

Q You also gave some testimony –

A I could expand on that at great length, but the FDA is not on trial today. I wish they were.

Q I agree. You testified that putting aside the intact D & X procedure or either of its two variations, the one described in Exhibit 24 or the one where the head comes out first, that putting that aside, abortion is already very safe [p. 89] in the United States, is that right?

A That's correct.

Q Is it also true that in general, medicine strives to make treatment safer and safer for patients?

A Yes.

Q And that's even if a procedure is already, quote, safe?

A Yes.

MR. HELLER: I have no further questions.

EXAMINATION

THE COURT: Doctor, before you step down, one of the criticisms, as I understand it, of the – what counsel have been referring to as the D & X procedure or the intact D & E is that it requires the insertion of a sharp instrument into the uterine cavity, at least to some small degree. In your testimony, I think you said that you didn't see that as much of a concern because you could visualize the head of the fetus when it was in the – as it was pulled down against the interior of the – of the cervical canal. Did I understand you right?

THE WITNESS: That's correct.

THE COURT: Would you explain to me?

THE WITNESS: I could try to draw it. Would that help?

THE COURT: Yeah, it really would, if you could. Perhaps the courtroom deputy will help you. Doctor, as in [p. 90] everything with the federal government, that will fall down in [sic] you aren't careful.

THE WITNESS: Just as long as it doesn't blow up, I'm all right.

THE COURT: I make no warranties.

THE WITNESS: We get to late in the procedure where that step we are talking about would be being performed. This would be the wall of the uterus, and this would be the cervix, and the fetal head would be right here bulging into the cervical canal. The neck is here. The shoulders are there. The surgeon's fingers are coming right over the shoulders like that with a finger on either

shoulder, the neck in between. The base of the skull is right there. The surgeon would actually, by pressing down, would actually be seeing the base of the skull. He's got his finger on either side.

THE COURT: There is a canal on either side of the fingers?

THE WITNESS: The neck is between the fingers.

THE COURT: All right. Go ahead.

THE WITNESS: If you envision somebody with their hand on your back, a finger on either shoulder pulling down, and so an instrument is guided right between those two fingers into the base of the skull.

THE COURT: As you describe that, do you see that [p. 91] procedure as particularly risky to the maternal health?

THE WITNESS: No. No.

THE COURT: All right. Thank you very much. Let's have that marked as Court's Exhibit number 1, please. I'll have the courtroom deputy do that. I may have raised questions in the minds of counsel. First for the plaintiff.

MR. HELLER: No, Your Honor.

THE COURT: For the defendant?

RECROSS-EXAMINATION

BY MR. SMITH:

Q Dr. Stubblefield, the procedure you have just described with that diagram, have you ever done that yourself?

A No, I have not.

Q Have you ever seen anyone else perform it?

A No, I've not.

MR. SMITH: Nothing further.

THE COURT: Thank you, Doctor. You may step down. For the purposes of clarifying the doctor's questions or answers to my questions, I would like to receive into evidence Court's Exhibit 1 which is the drawing.

MR. SMITH: And just so I can understand, if it's received solely for the purpose of explaining his testimony, I have no objection for it being received for that purpose. If it's received for the purpose that it actually does show that it's a safer or it's a safe procedure, that I would [p. 92] object to.

THE COURT: Well, I simply want it in the record to describe what he told me.

MR. SMITH: On that basis, I have to [sic] objection.

MR. HELLER: No objection, Your Honor.

THE COURT: It's received. Counsel?

MR. HELLER: Plaintiff has no further witnesses, Your Honor.

THE COURT: Let me make clear, are you both agreed, or are both sides agreed that I'm receiving into evidence for purposes of the trial all of the testimony that was previously received into evidence?

MR. HELLER: Yes, Your Honor.

MR. SMITH: Yes, Your Honor, and so it's clear, there was a stipulation that went in conjunction with the exhibits at the preliminary hearing, and both parties are understanding that stipulation also applies because some of the exhibits at the preliminary injunction were received for a limited purpose pursuant to that stipulation.

MR. HELLER: That's correct, Your Honor.

THE COURT: All right. With that understanding, then, plaintiff rests?

MR. HELLER: That's correct, Your Honor.

THE COURT: Thank you. Counsel?

MR. SMITH: Your Honor, the evidence that we would [p. 93] have presented for our medical expert has already been received in the form of a deposition of a medical expert, Dr. Frank Boehm and also a videotape of his testimony. I know that the Court will review the deposition and the videotape and in making its decision with that understanding, we'll rest at this point.

THE COURT: As I told you at our pretrial conference, I'm happy to sit here and watch the videotape with you, if you would like me to, as I tell everybody, I do read depositions, I do watch videotapes in the privacy of my chambers. I'm happy to do that. It saves you all time

and money, but if you want me to watch it here in front of you, I'm happy to. My understanding is neither side has requested that.

MR. SMITH: I don't think that's necessary, Your Honor.

THE COURT: Nor do I.

MR. SMITH: And I think in view of judicial economy and time and expense, I don't see any point doing that.

THE COURT: I'm very appreciative of that. Thank you, counsel. Any rebuttal?

MR. HELLER: No, Your Honor.

THE COURT: All right. You're going to submit your briefs, and I think those will all – Really, the only question I want to readdress to plaintiff, we have one [p. 94] plaintiff here, and if your challenge is facial and it goes beyond previability, do you have standing.

MR. HELLER: Your Honor, just briefly to address the Court's question which we hope to address more fully in our briefs.

THE COURT: Right.

MR. HELLER: I believe, or we believe in general, courts have examined abortion statutes. Whether they were challenged by an individual doctor or by a larger group of abortion or women seeking abortions, once there is a finding the statute violates the Constitution, the statute is enjoined on its face because anyone likely in the future to be affected by the same statute would raise identical legal and factual claims.

THE COURT: See, I'm not sure that assumption is fair here. Dr. Carhart was very careful to tell me that, as is Dr. Stubblefield, their experience with regard to previability abortions, the Haskell D & X, if you are asking me to judge that in the abstract after the fetus becomes viable, that seems to me to be a much more – Well, seems to me to pose very different questions. The mortality risks become different, and I don't have a plaintiff here who has an incentive to litigate that.

MR. HELLER: Absolutely, Your Honor. We have – Let me try to be a little bit clearer about what I'm trying [p. 95] to say. Our primary concern remains that our client be protected from prosecution under the statute.

THE COURT: Right.

MR. HELLER: However, I think there are, the Court can, for example, can enjoin a statute in part.

THE COURT: Right.

MR. HELLER: In certain applications and not others. My concern about addressing this now is that, for example, the Sixth Circuit recently in the *Voinovich* case looked at a differently worded statute prohibiting D & X abortions and looked at it first in terms of its applications prior to viability, and then instead of actually analyzing the substantive constitutionality of the statute post-viability, instead made a determination that it could not take a statute which appeared on its face to apply throughout pregnancy and narrow it to a post-viability statute, that it had to take the statute as it found it and could not – So I think their concern is more about severability or scope of injunction.

THE COURT: All right. All I'm telling you is, you really do need to be very careful to spend some time on this, and with regard to that, I'm not sure that's correct because one of the questions I have got to ask myself is, does Dr. Carhart have an incentive to provide me with information regarding post-viability abortions? and if he doesn't, and [p. 96] the state has had no opportunity to respond to it because he's not presented any evidence, do I have a live case or controversy, really, about that?

MR. HELLER: Absolutely, Your Honor, and I think one of the things we want to address in our brief is certainly, what period in pregnancy does Dr. Carhart – does our client have standing to challenge the statute as to. Nevertheless, that's, I think, different from the question of whether the Court would make, let's say, a holding that enjoins the statute as applied only to Dr. Carhart before viability, or a holding that the statute, based on the evidence presented, is unconstitutional prior to viability, essentially a declaration of that so that if another doctor moved into Nebraska who wanted to do prohibited procedure at 18 weeks, that doctor would not then have to come into court again and repeat a trial like this in order to get protection.

THE COURT: But as a practical matter, Justice Scalia said that it's not only – if Dr. Carhart wins, it's not only for him even under the – as applied. It's for people who are similarly situated.

MR. HELLER: And with that understanding, Your Honor I think –

THE COURT: I mean, isn't that what Scalia said?

MR. HELLER: I'm not sure. Which case?

[p. 97] THE COURT: In the *Guam* case.

MR. HELLER: In his dissent in the *Guam* –

THE COURT: Yeah.

MR. HELLER: Yeah, I think Justice Scalia was talking about that to some extent, but with that understanding, I think the Court and us, we may have a different conception what as applied means in this context. We may be talking about the same thing, but if, for example, if the Court says as to previability abortions, the statute is unconstitutional, it enjoins its application to Dr. Carhart, that will, in all likelihood, protect any future provider who is similarly situated. I agree with that Court about that, and we certainly intend to address these issues very clearly and in detail in our post-trial brief to the Court.

THE COURT: Okay. I think the analysis becomes quite different if this is a facial – may – Let me say may become quite different.

MR. HELLER: Clearly, there is a lot of dispute in federal courts among the circuits about what standard applies to facial challenge to an abortion statute.

THE COURT: Right.

MR. HELLER: We believe the Eighth Circuit has ruled on that in a definitive way. Nevertheless, the Court would certainly avoid some thorny issues.

[p. 98] THE COURT: I'm told it really doesn't make any difference what I do, it's going up, so – But if I can avoid a whole lot of work, if it doesn't make any difference, then I would like to avoid that.

MR. HELLER: And we will certainly consider that in formulating our statement of what relief we seek.

THE COURT: Earlier, I had indicated that the practical effect of holding a statute unconstitutional as applied is to prevent its future application in a similar context but not render it utterly inoperative. To achieve the latter result, the plaintiff must succeed in challenging the statute on its face according to Justice Scalia. And I indicated that as long as he, meaning Dr. Carhart, limits his challenge to how the law is applied to his situation, a favorable ruling for Carhart will not invalidate the Nebraska law generally. Such a ruling would only preclude enforcement of the Nebraska law against Carhart and his patients and other similarly situated doctors and their patients. That's what I understand as applied means.

MR. HELLER: Thank you, Your Honor. It will help us in having your understanding in determining what relief we are seeking.

THE COURT: That's at 920 – 972 F.Supp, I think it's 522 or 523. Now, you know, I just may be wrong, but the prudential concern about – as applied and facial, there is [p. 99] no – if we have – if we have Dr. A who does the same thing as Dr. Carhart, and I would happen to hold for Dr. Carhart in this situation, there is no prudential concern that would suggest that Dr. A would

have to relitigate this. I understood the prudential concern to be that the facial challenge takes you beyond a circumstance in which you have evidence presented to you by an active litigant and provides and may provide to you a situation in which you have to test the statute against an abstract set of facts.

MR. HELLER: Absolutely, Your Honor. We may be very much talking about the same thing. What I might describe as a ruling that the statute is invalid on its face prior to viability may be the same as what, in somewhat different words, what the Court is describing as a ruling that the statute is invalid as applied to abortions prior to viability. When I have used the term as applied, the way I have been using that is more in the sense of as applied to a particular individual, but given the Court's understanding as expressed in the preliminary injunction, that the meaning of as applied challenge with Dr. Carhart as the plaintiff, I think that will affect, certainly, the relief we seek.

THE COURT: Well, that's tentatively what I think as applied means. If you or somebody like you comes before the Court and there has been – If I make a ruling for Dr. Carhart and somebody comes before the Court who is like Dr. [p. 100] Carhart, then that injunction that I would issue would apply to Dr. Carhart and others like him.

MR. HELLER: Again, Your Honor, I just want to – The reason we want to, I think, hold this issue for our brief is that if, for example, the *Guam* dissent, Justice Scalia, I think, pointed out that the *Guam* statute which banned most abortions but had exceptions for the

woman's life and for certain threats to the woman's health, that that statute might be constitutional as applied after viability. Nevertheless, in that case, the federal district court as well as the Ninth Circuit struck the statute on its face.

THE COURT: Right.

MR. HELLER: I think we need to at least examine and present to the Court what appears to be the differing options with respect to that and what relief be [sic] seek, in the sense that Justice Scalia's view appears to be [sic] a dissenting view, although it may identify some prudential concerns that the Court should be rightly aware of in framing its relief. I'm not sure if I'm being very clear.

THE COURT: When we get into facial challenges, the question, I think, becomes whether there is any circumstance in which the law could be constitutional. I think that may be the test, and if there is, you lose.

MR. HELLER: I understand that. Certainly, under that test, it's virtually impossible to prevail on any facial [p. 101] challenge. It's our view, however, that the Eighth Circuit, at least, has rejected that test in the *Planned Parenthood vs. Miller* decision from, I think, about two years ago, although we recognize the Supreme Court has not definitively rejected that, so we also recognize that this Court, to avoid that issue –

THE COURT: I have got to do a multi-part analysis maybe.

MR. HELLER: Possibly.

THE COURT: And if it doesn't matter what I do anyway, then save me from that effort, would you?

MR. HELLER: We are going to really, Your Honor, we will seriously consider the relief we are going to ask for, and we are, you know, I don't want to, without talking to my client further about this, commit ourselves to one way or another, but certainly, our interest is in judicial economy and reducing the need for unnecessary rulings.

I just want to add one more legal issue that arises. One problem, I think, that comes from another body of cases having to do with this question of facial versus as applied is the problem that arises when a court essentially limits applications of the statute, because in doing so, the court may create in essence a new statute that perhaps is better left to a legislature to create in the sense that, for example, if this Court were to facially validate the statute [p. 102] the Nebraska legislature would certainly have the option of enacting a new statute saying we are banning partial-birth abortions after viability, so I just mention that as a competing prudential concern.

THE COURT: You don't want me to construe the statute in a way to limit its reach?

MR. HELLER: In a way that the Nebraska Legislature itself might not want to limit its reach. So that's a competing federalism or prudential concern that I think we need to at least possibly brief to the Court.

THE COURT: Of course, the defendant says that one ought to do that if one can construe the statute in a way to make it constitutional, one ought to do that.

MR. HELLER: There is that general principle. However, on the other hand, our review of the floor debates on this bill make it very clear that the chief sponsor and proponents of the bill, they repeatedly indicated that the statute was not to be limited to post-viability, and I think that's pretty strong evidence that even the Nebraska Supreme Court that was looking at this would say this statute wasn't meant to do that. Now, that's a separate question of whether it actually conflicts with the legislative intent to limit it that way.

THE COURT: Thank you. Counsel, do you wish to add anything?

[p. 103] MR. SMITH: No. It's clearly a matter of briefing it. I don't think there would be anything we could add to it at this point.

THE COURT: Do you have a preference one way or the other about as applied versus facial?

MR. SMITH: Frankly, my preference, after listening to the debate, is to do the research and respond at that time. I think it would be difficult for us to state right now.

THE COURT: Well, give some thought to it.

MR. SMITH: Oh, sure.

THE COURT: It not only affects the plaintiff, but it affects you either way I go in this case. Seems to me I ought to be as clear as I can, and if I were to hold for the State in this case and have to go through a multi-tier analysis, this is what the analysis would be if we forget *Miller* and this is what the analysis would be if you apply *Miller*, and you can avoid all that if you agree and they

agree that it's applied and what applied means. Then it seems to me for everybody, it's clearer. All right. I will issue a briefing order. Once again, my compliments to counsel. You've been very pleasant to deal with in this otherwise hotly contested matter. I appreciate counsels' civility one to the other and to the Court. There being nothing further, we stand in recess.

[p. 104] (Recess at 12:04 p.m.)

CERTIFICATE

I, David C. Francis, certify that the foregoing is an accurate transcription of the record of proceedings made in the above-entitled matter.

/s/ David C. Francis DATE: March 25, 1998
Official Court Reporter

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 3

TRANSCRIPT PREPARED BY THE
CLERK OF THE LEGISLATURE
Transcriber's Office

April 11, 1997

LB 23, 167, 217

* * *

[p. 3959] SENATOR MAURSTAD: That's correct, Mr. Speaker. Senator Brashear was not able to be with us this morning for a variety of reasons, and in discussion with the Vice Chairman of the committee and Senator Brashear, a decision was made for me to handle the committee amendments. I know that Senator Brashear would like to be here and looks forward to being involved in the deliberation of LB 23. The committee amendment combines aspects of Legislative Bills 167 and 217, which were indefinitely postponed by the committee, with LB 23. It amends the definition of "partial-birth abortion", adds a provision providing that no woman upon . . . a partial-birth abortion is performed, shall be prosecuted under the bill, amends Section 71-148 relating to loss of licensure to practice medicine, to harmonize with other provisions of this bill, and adds the emergency clause. The definition of a "partial-birth abortion" is amended in accordance with the definition used in the federal bill. It differs from the federal bill only in that "unborn child" is used in place of "fetus". The green copy of LB 23 says "partial-birth abortion means an abortion

procedure in which the person performing the abortion partially vaginally delivers a living child before killing the partially-born child." The committee amendment changes that to "partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child." The change to "unborn child" was made to harmonize this new section with all other Nebraska abortion statutes, all of which consistently use [p. 3960] the term "unborn child" to refer to the baby prior to birth. The federal bill as passed by the U.S. House uses "fetus" in both places, although the Judiciary Committee version used "fetus" in the first instance, "infant" in the second instance, and then provided a definition that stated the terms "fetus" and "infant" are interchangeable. The second change adds a section that was in one of the other bills that no woman upon whom an unlawful partial-birth abortion is performed shall be prosecuted, and under this section . . . under this section or for conspiracy to violate this section. The third change harmonizes the provisions of LB 23 that that provision for a suspension and revocation of the medical license of a physician who performs an unlawful partial-birth abortion, a provision is added to Section 71-148 as to the definition of "unprofessional conduct" that can result in the loss of the license. The final change is that the emergency clause has been added to the bill. Mr. Speaker, that's an explanation of the committee amendments as advanced from the committee. And once again, I would like to invite good discussion, good debate, good deliberation on LB 23. I look forward to trying to answer, along with others on the floor that have a definite interest in

this bill and have always had an interest in this bill, any questions that come about. Look to effectively address the amendments that may come before us, and continue to work towards the passage of the bill. With that, I'll end the opening on the committee amendments.

* * *

TRANSCRIPT PREPARED BY THE
CLERK OF THE LEGISLATURE
Transcriber's Office

May 12, 1997

LB 23

* * *

[p. 6378] SENATOR BROWN: Mr. President, members of the Legislature, this amendment would add language which appears in model language authored by the National Right to Life Committee to LB 23. I have passed around a copy of an excerpted November 22, 1996, National Right to Life Committee mailing that includes this particular language. The amendment would add a necessary exception to the proposed ban. On page 3, line 21, and on page 6, line 13, after "injury" it would insert "including a life-endangering condition caused by or arising from the pregnancy itself". LB 23, as proposed, provides that the banned procedure cannot be performed unless a woman's life is endangered by a physical disorder, a physical illness, or a physical injury. In attempting to determine whether all the potential problems that could arise in a pregnancy were covered by these three areas, physical disorder, physical illness, and physical injury, I spent a lot of time with dictionaries and I learned that I appreciate abridged dictionaries much more than I

did before. The conclusion, though, is that a pregnancy is not a physical disorder, it's not a physical illness, nor is it a physical injury. A pregnancy can exacerbate several medical conditions, and sometimes the pregnancy itself can endanger the life of the woman. I then. . . . After I looked for the definitions of "disorder", "illness", and "injury", to see if that covered all the areas that could be a potential problem, [p. 6379] there was not, consistency among the dictionaries about the definition of "disorder", "illness", or "injury", other than "illness" was defined as sickness, and "sickness" was defined as illness. There was some consistency among the three states in terms of the use of the word "abnormal". It was recurring several times, abnormal. And I think it's clear, from then moving on to the description of "pregnancy", that pregnancy is not necessarily an abnormal condition. In fact, both the dictionaries and medical authorities that I contacted described pregnancy as a condition, not as any sort of illness, disorder, or injury. In fact, the EEOC has an interpretation on pregnancy that is for the purposes of the Americans With Disability Act, which explicitly excludes pregnancy, because it is not the result of a physiological disorder. So I believe this amendment is necessary to make it clear that life-endangering conditions caused by or arising from pregnancy are included within the exceptions to the prohibition. After looking at regular medical dictionaries and not feeling that I was . . . felt comfortable that disorder, illness, or injury and pregnancy, that I had definitions that felt comfortable to me, I moved on to a medical dictionary, the *Stedman's Medical Dictionary*, to examine the medical definitions of the three areas and pregnancy. And I would like to share

with you the *Stedman's Medical Dictionary* descriptions of "disorder", "illness", and "injury". "Illness" is defined as sickness or disease. "Disorder" is defined as a disturbance of function, structure, or both, resulting from a genetic or embryological failure in development, or from exogenous factors, such as poison, trauma, or disease. "Injury" is defined as the damage or would of exogenous trauma. So in both those cases we are talking about exogenous, outside the body situations, whereas pregnancy, obviously, is an internal situation. Then I looked at the kinds of situations that could be life-endangering because of pregnancy. And in most cases those are things that are exacerbations of existing conditions, exacerbation of heart disease, of hypertension, kidney disease, diabetes, sickle-cell anemia, vascular collagen diseases, and those are all, I think, fairly, certainly illness. The very vagueness of the word may be . . . may make it easier to define those things within that category. There are certain things, though, that are not as clear. Conditions such as toxemia, which is defined as an ill-defined term referring to metabolic aspects of pregnancy, characterized by hypertension, edema, [p. 6380] albuminuria. And so it's not clearly . . . it's not as clear that that is an illness, it is a combination of things. Also, choriocarcinoma, which is carcinoma of the placenta. And the placenta is described as a temporary organ of . . . that develops during pregnancy to nourish the fetus and carry away waste, a temporary organ. And so it's not as clear that that is something that is covered. But the area that I'm most concerned about are those things that constitute emergency situations, hemorragic conditions, such as placenta abruptio, thrombocytopenia purpura, which is a very rare

but deadly clotting disease which is related directly to pregnancy. Some doctors believe that this can be managed through steroids, but it is a very deadly disease that has killed a Nebraska woman within the last year. These are the situations that I think we really need to make sure that . . . they're the ones that probably the exception is the most necessary for, and we really need to make sure that they are included. But it was never my intention to have this amendment be some sort of chicanery that circumvented the ban, and there have been some allegations to that extent. And so in that regard, I would like to ask unanimous consent to withdraw the amendment and substitute.

SPEAKER WITHEM: Senator Brown has requested that this current amendment be withdrawn and that she be allowed to substitute a new amendment. Is there any objection? It is so ordered.

SENATOR BROWN: The new amendment just adds . . .

SPEAKER WITHEM: This is a new amendment. Mr. Clerk, you wanted to reference the amendment for us.

CLERK: Senator, FA249, was the one?

SENATOR BROWN: Yes.

CLERK: Right. (See page 1898 of the Legislative Journal.)

SPEAKER WITHEM: Senator Brown, you are now recognized to open on your amendment.

SENATOR BROWN: This amendment simply adds the word "physical condition" to the previous amendment. So it says, "including a [p. 6381] life-endangering physical condition caused by or arising from the pregnancy itself". As I said, it was never my intention to have it be anything but. We are going to have an opportunity to talk about other kinds of health exceptions. This was, in my mind, always a physical situation. Pregnancy, to me, is a physical situation, life-threatening is a physical situation. And I think that just to make that clarification, and language is important, it was important to add the word. And we can go on and talk about more expansive kinds of health issues on some later amendments, I think, that are going to be offered. But I am very serious about this amendment. I do think it's an important consideration. I hope that we will have a discussion on the merits of the amendment and not just on the bill itself, but on the merits of this amendment, because I do think that it is an important area. The ban that we are talking about in this bill, it's a very difficult, virtually maybe impossible to defend procedure. But it is in these emergency situations where time is of the essence, that I think that the procedure may be justifiable. And so I would ask you to seriously consider those very immediate kinds of life-threatening situations and whether we have clearly enough, in the language that is currently in the bill, addressed those areas. Thank you.

SPEAKER WITHEM: Thank you. We are now discussing the substituted Brown amendment. Senator Landis.

SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. I support the Brown amendment. It has to do with what I think is the underlying purpose. Senator Maurstad introduced the bill and said there was an exception for the life of a mother. Generally speaking, we have statutes on this subject that talk about the life of the mother. They've never used the kind of language which we have in LB 23. LB 23 is the first time that we have the life of the mother exception narrowed down or limited, in which its unclear whether the life of the mother is protected.

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[p. 6389] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. This is the very first time we've ever limited the life exception in abortion. We've never done this before. We've got it several other places in the statute, it's very clear, but this is the first time we have tried to limit or, in this case Senator Maurstad is limiting the life of the mother exception with this kind of language. Doesn't appear anyplace else. Senator Crosby mistakens the Brown amendment's place in the bill. Understand, this is only when the life of the mother is in jeopardy, this is not for any other justification, this is not an expansion of anything else, except when is it that the mother's life could be in danger. So this has nothing to do with broader and longer lists of exceptions. And the fear that's commonly there, for example, when you use the word "health", there, for example, pro-life supporters say, look, if you use health, that could be mental, that could be wide open, you could manipulate that. This is limited to one and only one

circumstance, and that's where a mother's life is in danger. We have never attempted to shackle that phrase with some, as Senator Maurstad says it's explaining material, but I listened [p. 6390] to that explanation, and if you thought that was a clear explanation, I bet you don't want to be in an emergency room having to solve these problems on a moment's notice with a felony at the ready, because that was clear as mud, as far as I'm concerned. What does the statute normally say? Well, if you've got your statute book, take a look at it, 28-329, existing law. No abortion shall be performed after the time in which, in the sound medical judgment of the attending physician, the unborn child clearly appears to have reached viability, except when necessary to preserve the life of the mother, period, boom, that's it. Now there's also the word "health", but we know that's a different issue. Okay? It says, necessary to preserve the life of the mother. It doesn't define it, it doesn't limit it, it doesn't put three special terms on it, it doesn't turn down what the National Right to Life movement has said is appropriate language, even when it was trying to explain. It said the right of the life of the mother is paramount enough. If that's threatened, you can use this procedure. Senator Maurstad, for the first time in Nebraska law says, that's not good enough, an exception for life isn't good enough, it has to be only one of these three threats to the life; if it's outside that list of threats, well, too bad, she doesn't get her life preserved, she doesn't get to use this practice, she dies. If I'm not satisfied, and by the way, I think, said Senator Maurstad, I think everything is on the list, I don't know, in fact I'm not sure whether pregnancy is or not. I guess it isn't an injury. I guess it isn't . . . it might be an

illness, he says, don't know for sure, but maybe it is. Are we going to allow this bill to pass in a maybe form as to whether the life of the mother is protected? This is good enough? We have, on more than one occasion, protected the life of the mother elsewhere, we have never attempted to put limitations on it, to try to explain it or clarify it, because, you know what, we said, we said it's the life of the mother, that's clear, that's clear, and it doesn't need any more. And it certainly doesn't need to be limited, as Senator Maurstad has done in this bill. Unfortunately, you can't understand the argument easily unless you actually open up LB 23, . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . if you don't actually look at the language, [p. 6391] because you'd think that the life of the mother is protected completely, but it's not. You can see it in Section . . . lines 8 through 18, through 22, page 3, Section 3, no partial-birth abortion shall be performed in this state unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury. Senator Maurstad isn't clear, where a pregnancy is in that. And, by the way, women die of pregnancies. Women who want to have children, who are in the birthing process because they want to be there, and the head of the child is too much of a trauma, and hemorrhaging begins, and the actual process that the mother wants to have to go forward can prove to be lethal.

SPEAKER WITHEM: Time. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. Speaker. As I indicated before, you have to look beyond

just this particular section when you're looking at what the issues that Senator Landis and Senator Brown raise. The description that he was just . . . and the example he was just going to use is not a situation where a partial-birth abortion was taking place. There has to be the intentional and knowing performance of a partial . . . an unlawful partial-birth abortion. Now, as I indicated before, and I'll try to speak for myself so someone doesn't have to explain what I'm trying to say, I hope that you will listen to what I have to say and use your own interpretation of what I have to say. This doesn't, as I indicated before, pose a real problem to the bill, as I indicated before. In fact, I think it has validity, had validity before. I indicated if the members want to include it, that's fine. I'll even go so far as to say, so that we can move on to the issues dealing with the health exception, I'll vote to adopt the Brown amendment. I'll recommend that we adopt the Brown amendment. National Right to Life doesn't have a problem with the Brown amendment. She's made the amendment more palatable, I agree. I don't know that it was particularly necessary that the word "physical" be included, but she's gone that extra step to do so. And so in good faith, I'll accept that and recommend that we go to a vote on the Brown amendment. I'm going to vote for it, we'll see if there's enough support among my colleagues to do that, then we can move on to the health exception, for which there is no explanation as far as I'm concerned at this point. So, with that, Mr. President, I'll [p. 6392] relinquish the balance of my time.

SPEAKER WITHEM: Senator Hillman.

SENATOR HILLMAN: Yes, Mr. Speaker, members. I think probably one of my concerns and why I'll support the Brown amendment is to be able to understand the situation that you have between the physician and the patient, and that we don't . . . aren't so restrictive in the language that we somehow interfere with that process, because the physician will be concerned about liability issues or that we have narrowed the definition when it comes to saving the life of the mother. In visiting with gynecologists that I have in my area, and we have a fine wellness clinic there that works very well with women, that has had an ongoing relationship, and they're not concerned particularly about this bill, other than they feel that the process . . . or that they've had . . . that they know their patients, that they've been able to work with them, they just want to make sure that there's nothing that's going to interfere with their decision-making process and the way that they can deal with women on a confidential basis. The other thing that I would like to mention relates somewhat to Senator Vrtiska's comments that there seems to be some type of, I'm going to call it a stereotyping, that if you discuss abortion related bills that you're automatically pro-abortion. And I guess I take exception to that. I think we need to look very carefully at any legislation that comes up that, addresses legality of abortions and how they are handled in the state. And one of the reasons I ask a lot of questions or try to understand the legislation that's being introduced is that I have always come down on the side of looking at what it means to have a choice for people to have some control over what their actions are. It does not mean that you are pro-abortion, it means that there are situations that you

want to see that can happen that, in the cases of abortion, that people do have a choice, it doesn't mean that you support abortion. And to automatically be labeled as pro-abortion is something that you're promoting or suggesting that you think it's a good method or it's something you would advocate for people to do, I take somewhat an exception to. It's. . . . I think we've asked questions on and tried to improve all legislation that comes in front of this body. And I think it most certainly behooves us on legislation that's abortion related that we ask those same [p. 6393] questions and see that we do protect the rights of . . . legal rights of women in the state of Nebraska, and so we question that legislation very carefully. It does not necessarily mean that we are "pro-abortion". And how much time do I have left, Mr. Speaker?

SPEAKER WITHEM: You have two minutes.

SENATOR HILLMAN: And, Senator Landis, if you would like to [sic] rest of my time, I'd be glad to yield it to you, otherwise I'll give it back to the Chair.

SPEAKER WITHEM: Senator Landis.

SENATOR LANDIS: I heard Senator Maurstad's speech and I was . . . I thought that was a helpful suggestion for our debate. What I'm unclear of is whether or not Senator Maurstad is in a position to accept the amendment as he just said he would and vote for it, which I think is a good idea and would allow us to move on, if, in fact, the rest of his colleagues who are signed onto the bill don't go along with it, we'll have to go back and revisit this issue. I'm hopeful that the body heard Senator Maurstad say he'd accept the amendment. And, if that's the case, my light is on and when that light

comes on I'd move to call the question and permit us to vote on the issue and move on, in the event the body is sufficiently well informed and agrees with . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . Senator Maurstad that this amendment should be adopted.

SPEAKER WITHEM: Senator Brown.

SENATOR BROWN: Mr. President, members of the Legislature, I feel the need to respond to a couple of the statements. Had it been my intention to broaden or to weaken the language of the bill, I'm not sure why I have used language directly from the National Right to Life Committee to do that. I'm not sure why they would have advocated this language in their model legislation. I think that there are very rare, and I admit that they are very rare, circumstances, emergency, immediate [p. 6394] situations. And I chose to believe the sponsors of this bill that they really intended to protect the life of the mother. And if there is any circumstance where this procedure, which is virtually indefensible, as I said before, where it is justifiable, it is in these very rare emergency situations, very immediate, and that is when I think we really need to make sure that we are protecting that woman, when she may not even be able to be a part of making the decision herself. Thank you.

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[p. 6398] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. This is both in your computer, and it's on your desk. We are talking about the health of the . . . I'm sorry, not the health, the life of the

mother exception. Because we are on a path that we've never charted before, which is limiting the health . . . I'm sorry, limiting the life exception for the mother. We have an interesting phrase here, understand this is only where the life of the mother is in danger. Senator Maurstad says, you know, under the circumstances there are . . . this partial-birth abortion should be allowed, and there are two sets of conditions. One, you have to be inside the physical disorder, physical illness, physical injury, and now the physical affects [sic] of pregnancy, one of those four limiting conditions. And in addition to being in that limited set of conditions, you also have existing law in this bill that says, and no other medical procedure would suffice for that purpose, no other medical procedure would suffice for saving the life of the mother. Now, the difficulty here is that since we've never limited the life exception for the mother before, except now in LB 23, we've never had to worry about what this kind of a phrase means. We've always said, look, the health of the life of the mother is the trump card, the life of the mother is the trump card, consistent with Catholic doctrine, and consistent with the ethical standards of the medical profession, it's consistent with the principle of self-determination, the life of the mother needs no definition, explanation, clarification, or certainly limitation. So we've never had a phrase like this before. And no other medical procedure would suffice for that purpose. Well, there are multiple procedures. What if a procedure that, if it's successful would suffice, is also risky? What if it [p. 6399] would suffice, but only in 30 percent of the cases? What if there's . . . what if this outlawed procedure would be . . . would be successful in saving the life of the mother

more often than that procedure, but that procedure, if it was successful, would be sufficient? What's the law say? It's not clear. Senator Maurstad's never made this clear, and my guess is he's going to turn his light on and tell us what he thinks this means. But since we've never limited the life exception before, and we've never had a phrase like this, no other medical procedure would suffice for that purpose, would suffice for that [sic] purpose. What isn't clear to me is that you get to use the safest method possible, whatever it is, including this partial-birth abortion. If that's the safest method, or as safe as any other and any other procedure runs the same amount of danger or more danger, you get to use this procedure. Senator Maurstad doesn't make it clear. He says, would suffice for that purpose. Here's what I say, strike "no other medical procedure would suffice for that purpose", which is this, you know, loosey-goosey, unclear language, and says, "any other procedure would pose equal or greater medical risk". So, the phrase would read this, and, by the way, remember, we're talking about the life of the mother, and no partial-birth abortion shall be performed in this state, unless the procedure is necessary to save the life of the mother, the life exception. And now we start these limitations, whose life is endangered by a physical disorder, physical illness, or physical injury, plus the Brown amendment, and any other procedure would pose equal or greater medical risk. Medical risk to who? To the mother, to her life. So we're still using this limited definition. We're still keeping the limits, but we're replacing what I think is language that you can't be clear about, no other medical procedure would suffice for that purpose, and substituting with a standard that I think we can

understand better, "and any other procedure would pose equal or greater medical risk", "equal or greater medical risk". Understand, this doesn't undo the fact that you have to mean the life of the mother, that has to be at risk, and it has to be at risk because of the . . . one of the four factors that it describes. Okay? We're down to very limited numbers. In that case, don't we . . . shouldn't we be free to use the safest procedure to the life of the mother? Isn't that fair that we be free to use what is as safe or safer than any other procedure, including if it happens to be this procedure? Do we have to authorize a less [p. 6400] safe procedure and risk the mother's life at a greater percentage, at a greater risk than using this? We're not talking about adding to the list of reasons beyond the life of the mother, we're not adding to that list. We're talking only where the life of the mother is at risk. And my question to you is, if that's the condition, shouldn't the doctor be able to use the safest procedure, or whatever the procedure is that is equally the most safe, whatever they are, given the conditions and what's best for the mother's well-being at that moment? We're after protecting the mother at this point, right, 'cause we're in the life of the mother exception, so that's the paramount goal. Shouldn't her safety be the paramount goal? And no other medical procedure would suffice for that purpose. What purpose? What purpose? No other medical procedure would suffice. You mean if it might work one in ten, or in that case it could suffice? That's it? Or does it mean the same thing? Are you trying to get at the same thing here? Look, the mother's safety is critical. We want to protect it, we think that's fair, and, look, we're trying to protect her health. If that's the case, why don't you say

it? Why don't you just say, look, where any other procedure would pose equal or greater medical risk? Then you could use this. Why? Because the trump card, the health of the mother is the most critical thing. I don't predict this amendment will be adopted. The fact that we are for the first time putting limitations on the life of the mother exception is disturbing to me. But if we do that, and if you are bent towards that end, it seems to me that you have to account for the safety of the mother. And where procedures are either equally safe as this one, or less safe than this one, this one ought to be free to be chosen so that the life of the mother can be protected. It's the alleged goal of the bill, and the riskiness of the procedure should be able to be counted, should be taken into account. And I can't see, on the face of the language, that it's taken into account. It is not clear that the riskiness of the procedure is accounted for in the language of LB 23. And the life of the mother and the safety of the procedure should matter, they should be important to us, and we should guarantee to a mother whose life is at risk that you get to use any procedure that will save her life, certainly a procedure that proves to be safer . . .

SPEAKER WITHEM: One minute.

[p. 6401] SENATOR LANDIS: . . . than others, or as safe as any other, in which case that procedure ought to be available to save her life.

SPEAKER WITHEM: Senator Chambers.

SENATOR CHAMBERS: Mr. Speaker, obviously I support Senator Landis' amendment. And I will listen to see, if people speak against it, what reason they would give. I hear so many times on this floor people talking

about family values, the sanctity of the family, inappropriate intrusiveness on the part of the government. Then with hobnail boots this Legislature is going to go trundling into the most intimate area of a woman's life. This bill is punitive. There is a hope, it seems, from the way I read the body, a majority of them, that a woman in this situation will forfeit her life. They want this to be a death sentence on a woman for contemplating this procedure. So, if, as Senator Landis' amendment would require, any other procedure would pose equal or greater medical risk, that is rational, if that is rejected, then what I'm saying is true. However, it's sugar-coated, however people try to pretend that they're so concerned about a fetus, this is a hatred toward woman piece of legislation. If they were merely interested in throwing up safeguards and restricting a medical procedure to those circumstances where they genuinely believe it ought to be utilized, they would, first of all, name it correctly, instead of resorting to what I call back alley, tavern, street corner language, which is all right out there, but this demeans the statutes. We don't even honestly say what this is. If it were a business issue, we would say, let the bill say what it means. If it were a tax issue, we would want everything precise and definite and expressed in the language of the tax environment, the tax universe. Here there is so much bitterness, hatred toward and contempt for these women that language is to be perverted, the statutes are to be distorted, medical procedures are to be twisted, tortured, and turned into something as hateful, grotesque, and bizarre as possible. I find the process that is contained in LB 23 to be bizarre and hateful. What business is it of the Legislature? You get the impression that, with all this

concern for fetuses, this Legislature is willing to bend over backwards to make sure that the children in this [p. 6402] world are properly cared for, that if the state can intervene in this situation, it certainly will see a responsibility to spread protective arms around those children who are children in being, not unborn, not potential, but children here among us. Yet I see these pieces of legislation that slash assistance and programs that will help those children grow and mature into healthy human beings. So when there is all this talk about what happens in the birth canal and prior to that, but no concern for . . .

SPEAKER WITHEM: One minute.

SENATOR CHAMBERS: . . . that which emerges from the birth canal, I have names that I apply to that, but I won't do it this morning at this particular point, but I may get around to it before we are through. I'm going to listen again to hear what the objection is to Senator Landis' amendment before I proceed. Having not heard that objection, all I can do is express my support for it and my reason for supporting it.

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. Speaker. This bill is about prohibiting a particular abortion procedure, partial-birth abortion. It is what it is. It defines exactly what we're trying to prohibit in the state of Nebraska. I. . . . Senator Chambers has mischaracterized the bill, has mischaracterized the terminology in the passage that we're discussing with the Landis amendment. This is not a death sentence. This is not demonstrating any hatred or contempt for women, he knows that. This is very clear what we're talking about when we

talk about "no other medical procedure" relative to the exception that now has been expanded on the floor this morning to include any complications that arise out of the pregnancy. I think it's very clear, no other medical procedure, any other procedure, I mean they're just two opposite ways. The Landis terminology is too expansive I believe. The way that the bill is written is easily understood, there's nothing complicated about it. We're talking about the life exception, we've made a provision for that. Quite frankly, there isn't any medical testimony that has been presented so far, to my understanding, that this procedure is the only procedure that is available to save the life of the [p. 6403] mother. In fact, most of the testimony that I've seen, most of the information that I've read is that there's no medical reason for a partial-birth abortion. And I want to again emphasize we're talking about intent, we're talking about an abortion procedure, we're not talking about a regular birth of a child here, so I don't accept the Landis amendment. He's indicated as much in his opening that he didn't expect it to be accepted. I think he's accurately gauged that. I agree with him that I don't believe that this amendment will be adopted. It shouldn't be adopted. We've made it an exception for the life of the mother, we've expanded it this morning for clarification, to make sure that any complication arising out of the pregnancy is now within the scope of this. It's never been discussed because we've never discussed a procedure such as a partial-birth abortion before, never limited it before because we've never looked, at the whole issue of taking a particular procedure at 24-weeks and beyond, and looking at saying, not that way. There's no medical reason that we need to

have partial-birth abortions in the state of Nebraska. There's no medical reason that would indicate that there is a life-threatening circumstance as a result of the abortion itself, so I don't think that this is necessary. I will continue to listen, as I have, see if a case can be made that the language should be changed from "no other medical procedure would suffice". If there is a medical procedure that would be there, be available, the language would allow it, if it's to address a life-endangering circumstance as a result of a physical illness, injury, or disorder. So, I think we're beginning, in my view, of starting to split hairs.

SPEAKER WITHEM: One minute.

SENATOR MAURSTAD: I think it's very clear and I oppose the Landis amendment. I hope that my colleagues will join me in opposing the Landis amendment. As I indicated before, this isn't punitive. We do care about this circumstance about both the mother and the child. So I'll continue to listen to see if there's something that I'm not aware of that would change the course of the discussion on the Landis amendment.

SPEAKER WITHEM: Senator Landis.

[p. 6404] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. If you got a feel for what's sufficient to . . . what "sufficient" meant out of that speech, you're better than I am. Simply saying it over again, "no other medical procedure will suffice for that purpose" is not definition, it is not clarity, and it is amazing to me that the health of the mother and the insurance that the medical procedure that we use to save that life be itself safe, is regarded as "splitting hairs". The

health of the mother is not splitting hairs. The procedure used to save her life is not hair-splitting. It deserves clarity, and there was no clarity in that speech whatsoever as to what the phrase "would be sufficient" . . . "sufficient for that purpose" means. Let's try again. Senator Maurstad, let me ask you a question, I'll try to do it fairly, I'll try to give you a chance to respond. But I actually want to try a response here. Tell me if there are two procedures, one of them is a partial-birth abortion, one of them is another, it could be prolonged labor, it could be a hysterectomy, it could be a caesarian, there are alternative measures to protect the life of the mother in this situation. Does your language say that the doctor is free to choose any of those procedures if those procedures . . . a procedure from among that list is necessary to save her life? If there's an . . . . I hope I've made the question clear, but I'll try again if it's not clear.

SENATOR MAURSTAD: No, it is unclear. Could you ask that question again . . .

SENATOR LANDIS: I'll try again. If there are two . . .

SENATOR MAURSTAD: . . . (inaudible).

SENATOR LANDIS: If there are two potential procedures, one of them a partial-birth abortion, one another one, a vertical caesarian, both might be tried to save the life of the mother. Is the doctor free to use the partial-birth abortion when another procedure exists?

SENATOR MAURSTAD: Yes. It says, "and no other medical procedure would suffice for that". You've indicated that no other medical procedure would.

[p. 6405] SENATOR LANDIS: No, in fact, I've said that there are two, there are two procedures, a partial-birth abortion and let's say a caesarian. In that case you couldn't use the partial-birth abortion, you'd have to use the caesarian, wouldn't you?

SENATOR MAURSTAD: Yes.

SENATOR LANDIS: Okay. What if the caesarian is a more dangerous procedure for the life of the mother?

SENATOR MAURSTAD: If it were, it would not be prohibited, but it isn't.

SENATOR LANDIS: If the caesarian was more dangerous, you could use the partial-birth abortion method of saving the life of the mother. Is that what you're telling us?

SENATOR MAURSTAD: Yes.

SENATOR LANDIS: Okay. So, when you use the word "sufficient" in there is this weighing, you got two procedures, if they're the same, don't use this one, use the other one. But if the other procedure is riskier, you would be free to use partial-birth abortion in the pursuit of the saving of the life of the mother. I think I've fairly characterized what you've said, but confirm that for me, if you would, that I've fairly characterized the argument you've just made, the point you just made?

SENATOR MAURSTAD: Senator, I don't know.

SENATOR LANDIS: All right, let me try it again. Here's my characterization of what you just said on the mike. You've got two procedures . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . and one of them is the partial-birth abortion, one of them is another one, a caesarian, prolonged continuation of birthing, whatever. Between these two, if one . . . if the . . . if the partial-birth abortion is less risky, if the other procedure is more risky to the life of the mother, the [p. 6406] doctor will be free to use the partial-birth abortion method to protect the life of the mother.

SENATOR MAURSTAD: Yes.

SENATOR LANDIS: Good, okay. In that case, there really isn't a difference between our points of view because I think that that should be the law as well. That is, the doctor should be able to pick the safest method to protect the life of the mother. Why can't we say that? I happen to agree with what Senator Maurstad just said.

SPEAKER WITHEM: Time.

SENATOR LANDIS: And I think the law ought to say that clearly.

SPEAKER WITHEM: Senator Dierks.

SENATOR DIERKS: Mr. Speaker, pardon me, and members of the Legislature, I just stand in opposition to Senator Landis' amendment. As far as I'm concerned the language of the bill is just the way it should be. I think it's been researched rationally, we've looked at it closely at this stage, there's no reason for us to make any adjustments in the bill, and I would oppose the Landis amendment. Thank you.

SPEAKER WITHEM: Senator Chambers.

SENATOR CHAMBERS: Mr. Speaker and members of the Legislature, as on other pieces of legislation, an outside group connected with the Catholic Church, primarily, is pushing this, Right to Life, they were mentioned here, Senator Maurstad said since their imprimatur was on Senator Brown's amendment, it could be adopted. So this is a particular religion's approach. And that's why some people, such as Senator Dierks had just said, will say there's no need for us to make any adjustments, our work as a Legislature has been done for us by others, and we should just roll over and accept it. Fortunately, and this is one of those that I call . . . those pieces I call trash legislation in every sense of the term, poorly written, pejorative, dishonest, inaccurate. I'm sorry Senator Dierks left, because I've heard him talk about various issues in the Ag Committee, [p. 6407] and I'm sure if we were discussing animals we'd be able to talk more about biological procedures in a more accurate fashion. I'm sure that those people on this floor who make their living in agriculture would not hesitate, if a fetal calf threatened a life of the mother, to get rid of that calf, if it meant cutting off each leg, cutting off the head and anything else, because they know biologically in this process what it takes to preserve the life of the mother. Then they want to pretend that somehow biological processes are different when they involve human beings. We are not equating human beings to four-footed animals, but we're saying, I am saying that the processes are the same. Sperm is sperm is sperm. We even had a bill here some years ago that was going to exempt the sperm of certain bulls from the sales tax. They didn't call it anything other than sperm, and that's what they call the

substance in a human being. But all of a sudden we'll have senators who will say that if you have one of these, and I'm using this terminology for popular consumption, if you have one of these calves that has a lot of water, a lot of fluid in its skull, and that could . . . that would prevent a normal birthing process, the calf is gone by the board, and there is no way that that calf is going to be a functioning creature when it comes out. But there are people on this floor who will say, well, if you have one of these children who is severely deformed or malformed, once you somehow birth it, however you have to do that. I'm surprised they don't have something in this bill that would say when you come to the front part of a woman's pelvis, where the bones join, you don't just take a meat ax and split it, and pry open her pelvis so that the opening is large enough for one of these large skulls to come through. I'm surprised they didn't think to put that in. I wish I hadn't said it, because now they might add that as an amendment, but it would show the true character of this bill and the attitude behind it. Senator Landis' amendment makes an affirmative declaration. Senator Maurstad's amendment, his language which he got from Pro-Life, or Right to Life, whoever they are, declares it in the negative. And again they use street language, meaning just ordinary words that people use, and they're not defined and they have no meaning in the law. But they have to be so careful that they do exactly what . . .

SPEAKER WITHEM: One minute.

[p. 6408] SENATOR CHAMBERS: . . . Pro-Life or Right to Life, whichever one it is, told them to do, that there can be no change in the language, even though those supporting it cannot define it, cannot say what it

means. This is a very serious area. And even though the majority of senators always jump on the bandwagon and do what they can to restrict a woman's right to terminate a pregnancy, I will speak just as strongly for her right to do that. And I don't care if people are offended, I'm far more offended at the cruelty in these bills. Fortunately, legislation of this kind is under attack in other states, and I think it will be struck down by courts. The worse this bill is, the better it is ultimately, the better in terms of the chances of it being struck down. They ought to attach an A bill to all these things, because they always are challenged in court . . .

SPEAKER WITHEM: Time, Senator.

SENATOR CHAMBERS: . . . and generally lose.

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. Speaker. I rise again in opposition to the Landis amendment. Once again want to indicate the purpose of the law to start with. When many of these partial-birth abortions that are taking place right now occur, it's when the child is viable. There are other means in which to take care of the circumstance that's presented by that. What we're looking at is trying to prohibit the use of this unbelievable procedure in the state of Nebraska to abort a child. Now, I want to indicate . . . I was not characterizing the issue of the life or the health of the mother when I made the comment relative to splitting hairs. Senator Landis knows that. I was talking about the difference between the terminology that he uses and the terminology that's in the bill in the way in which you can say something is similar by words. I will try to be as clear as I can. And I

apologize, Mr. Speaker, to the members if I'm not as clear and my clarity is not to the standard of some members. I'm trying my best, as other members try their best, in explaining the provisions of the bill. But when given . . . giving an answer is not accepted and then is . . . just indicated that it's unclear, unwillingness to accept it because [p. 6409] of the unclearness, I apologize for that. I'm trying to be as clear as possible. I think people know what "physical disorder" is, "physical injury" is, "physical illness" is. Now, I can haul out dictionaries and terminology and we can go and talk about what all those things mean. I think people know what they mean. People know what "partial-birth abortion" means. It's when a child is partially delivered. Every part of the child is outside the womb of the mother except for its head. And the head is only kept in there for one reason, and that's to perform the abortion. And that's why it's called a "partial-birth abortion", and we'll probably get into that dialogue a little bit later on a proceeding . . . on an amendment that will be coming forward later, talking about specifically that language. But I would say, again, that I think it's clear . . . I'm not going to stand up here and be redundant, as indicated. I think Senator Dierks probably hit the nail on the head. He likes the way the bill is written now. I like the way the bill is written now, as amended by Senator Brown's amendment that I agreed to that addressed, I think, a need that needed to be addressed. But I think it's very clear that what we're saying is, there's an exception for the life of a mother when were looking at a partial-birth abortion procedure, and the intent of that, and no other medical procedure would suffice, then partial-birth abortion can be used.

When there is another medical procedure that would be . . . that would suffice, you would use that. So I'd ask my colleagues to vote against the Landis amendment.

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[p. 6412] SENATOR CHAMBERS: Senator Maurstad, you and Senator Dierks have talked about how perfect this language is, and Senator Dierks can be at least be considered a quasi-scientist. I'd call him a scientist. Show me in this bill where it says that a partial-birth abortion means that all of the child has been delivered except for the head. I don't see that in the language.

SENATOR MAURSTAD: The language on page 3, and it's cited again later, Senator Chambers, indicates that "partial birth means", and then it goes on, "perform the abortion partially delivers vaginally a living unborn child".

SENATOR CHAMBERS: Where does it say, as you . . . are you willing to admit that the description you gave is not what's in the bill? You said, all is delivered except for the head. That's not in this bill, is it?

SENATOR MAURSTAD: No, it says "partially delivered".

SENATOR CHAMBERS: And that could be a foot.

SENATOR MAURSTAD: That could be a foot.

[p. 6413] SENATOR CHAMBERS: So your statement was inaccurate, and if we look at this language, we don't really know that this means what you said it meant earlier, do we?

SENATOR MAURSTAD: My statement was an accurate explanation of the words in the bill.

SENATOR CHAMBERS: Why don't you write in this bill what it is you mean if you mean everything is outside except for the head? Because Right To Life didn't put that in their model bill, isn't that correct?

SENATOR MAURSTAD: No, Senator Chambers. As . . . I don't believe you were at the hearing where this bill was up, but I . . . at that hearing I indicated that I did not introduce LB 23 on the behalf of any organization.

SENATOR CHAMBERS: Well, I don't care about . . .

SENATOR MAURSTAD: I used . . . well . . .

SENATOR CHAMBERS: I don't care about that.

SENATOR MAURSTAD: But that's . . .

SENATOR CHAMBERS: I want to know where the language came from.

SENATOR MAURSTAD: The language came from the bill that was adopted by both houses of Congress and sent to President Clinton.

SENATOR CHAMBERS: And who . . . where did that language come from?

SENATOR MAURSTAD: I think that language was a compilation of a number of people that were in . . . and groups that were interested in this particular issue.

SENATOR CHAMBERS: I was told . . . I heard earlier this morning about Right To Life supporting the language that Senator Brown put in and the model language that they came up with, and that seems to track pretty much what Congress did. Is that correct?

[p. 6414] SENATOR MAURSTAD: They . . . that amendment indicated what National Right To Life's . . . that they approved that language. It didn't say that they drafted the language.

SENATOR CHAMBERS: Why are you so shaky and unwilling to acknowledge what we all know to be the case?

SENATOR MAURSTAD: I'm not shaky.

SENATOR CHAMBERS: What's wrong with it?

SENATOR MAURSTAD: I'm not shaky at all. I don't think there's a problem at all with people understanding, and that's why I brought it to everyone's attention that National Right To Life supported that particular language. National Right To Life has had involvement in this bill, as has . . .

SENATOR CHAMBERS: And National Right To Life means that everything of the child is outside except for the head, isn't that true?

SENATOR MAURSTAD: No. They would indicate that they would be supportive of the language that's in . . . that a partial-birth abortion is defined as abortion when the child is partially delivered.

SENATOR CHAMBERS: And "partially" means anything. A toe. Is that what Right To Life was concerned about, that the toe of a child might be outside . . .

SENATOR MAURSTAD: National Right . . .

SENATOR CHAMBERS: . . . the birth canal, and that's why they want this legislation?

SENATOR MAURSTAD: National Right To Life is concerned about a viable fetus being aborted by this particular procedure.

SENATOR CHAMBERS: Members . . . thank you, Senator Maurstad. Members of the Legislature, what I want the record to show is that . . . we're not legislating here. This is rubber stamping. [p. 6415] Senator Maurstad knows what he thinks this language means because he knows what the discussion . . .

SENATOR BRASHEAR: One minute.

SENATOR CHAMBERS: . . . has been based on. But the language in the bill does not say that. The definition does not say that. And it does not name the medical procedure involved, so all that a physician would have to do is say, there is nothing known to medicine as what's talked about in this bill. There is a procedure that we use, and that is the procedure which was used, and it has not been made unlawful under Nebraska law. This is a sham and a shell game as all these types of bills are. I'm in support of Senator Landis' amendment.

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[p. 6416] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. My first source of

concern is that LB 23 . . . it's the first time we've ever put limitations on the right of the mother to protect her own life. We've never done that before. And Senator Witek said that, in fact, those are all existing elsewhere in law, but they are not preserved in this situation. Senator Witek is mistaken in her reading of existing law, because when you get to this situation and the life of the mother is in danger, what LB 23 says, we're going to take off the table the partial-birth abortion method, unless it meets these qualifications. And if her life is going to be lost . . . but these limitation words aren't met . . . well, too darn bad, but this is off the table. The whole goal of the bill is to take partial-birth abortion off the table, and this is the exception area for the life of the mother. The life of the mother in this case, for the first time, is limited, and secondly, it's not only limited by the set of conditions and circumstances, but it's limited if there is another medical procedure which would suffice for the purpose of saving the life. Now, luckily, on [p. 6417] the floor, Senator Maurstad said, look, if the partial-birth abortion method is the safest method, then you can use it to save the life. And that we agree on. Where I think it also should be the case is that if the partial-birth abortion method is as equally safe as any other method, that it should be the doctor and the mother, who will have to live with the consequences of these choices anyway, who should make that choice. And for me, that's a much better description of the words "suffice for that purpose". That's the one that's in the green copy of the bill. Unclear, Senator Maurstad made it clear in his floor speech, but you can't look at the green copy of the bill and know what that means. We now have a clearer description of it, given the

floor debate, and between Senator Maurstad's description on the floor and my amendment and his bill, my amendment is a lot closer to what he said than the green copy of the bill is. I would ask that the introducers say what they mean. Senator Maurstad's done it on the floor. I applaud him for it. The green copy of the bill does not clearly say that. My amendment far more clearly captures what Senator Maurstad said than what's in the green copy of the bill, and I'd just ask you to say, in plain English, what you mean by the bill. That's what this amendment does.

SENATOR BRASHEAR: Thank you, Senator Landis. Members, you have heard the closing. We will proceed to vote on AM2065. All those in favor, please vote aye. Those opposed nay. Have you all voted? Mr. Clerk.

CLERK: 12 ayes, 19 nays, Mr. President, on adoption of the amendment.

SENATOR BRASHEAR: The amendment is lost.

* * *

SENATOR SCHIMEK: Thank you, Mr. President, members of the body. You'll find the amendment on your gadget. I'm having a hard copy passed out, too, but let me tell you verbally what the [p. 6418] amendment does. Again, it addresses the language on page 3 and page 6. On page 3 in line 21 and page 6 on line 13, and after "injury" you would insert . . . and this may have to go actually up to the additional language that we adopted of Senator Brown's . . . but it would say, "or if in the best clinical judgement of the attending physician a

woman's fertility or physical ability to carry future pregnancies to term is at risk." I can't imagine that members of the body would not want to provide for these exceptions. The intent of LB 23 maybe to prohibit the intact D and E abortion procedure. However, the ban could affect other medically necessary procedures not related to abortion. Whether used as an abortion method or for other pregnancy-related medical purposes, it is essential to provide an exception to protect a womans fertility and her ability to carry future pregnancies to term. To help understand the need for this amendment, I provide a scenario that a local OB/GYN presented to me which reveals the complexity of medicine and the dangers inherent in trying to impose blanket bans. And I apologize because I think all of us are somewhat at a loss on this floor because we don't know about some of these different complexities, but a woman who I will call "Jane" is having a spontaneous abortion, or miscarriage, in the second trimester of pregnancy, prior to fetal viability. When Jane arrives at the hospital, the fetus is in the birth canal, partially expelled, feet first, and the head wedged in the cervix. It has a heartbeat. The doctor will try medications and other methods to help Jane complete the miscarriage. However, if the fetus is not expelled after a period of time, major problems can arise that threaten her life and health, her fertility, and her ability to carry future pregnancies. Among the problems that can arise are bleeding. In the second trimester of pregnancy the cervix is firm, hard, and not in any way ready to dilate. If the fetus' head is stuck in the cervix, the uterus is not able to contract. Uterine contractions are necessary to stop bleeding which can threaten Jane's life. Another potential

problem is infection, which can set in very rapidly in these situations. Infection can lead to uterine scarring and adhesions in the fallopian tubes, both of which can make a woman sterile. Adhesions in the fallopian tubes also can lead to ecotopic [sic] or tubal pregnancies, which are always fatal to an embryo and dangerous for a woman. If not diagnosed and treated early, the tube can rupture, threatening a woman's life. Often, [p. 6419] the whole fallopian tube, occasionally with the adjacent ovary, has to be removed. In Jane's situation, the doctor cannot simply use force to pull the fetus from her body. Surgical intervention is necessary to prevent excessive bleeding and infection. The only options are to make the cervix larger or to compress the head of the fetus. Cutting the cervix, however, presents the potential for serious, even deadly, complications. If the doctor tries to cut Jane's cervix to increase its size, there is the risk of cutting into her bladder or rectum. Her cervical branch of uterine arteries would be at risk as well. If these major arteries are cut, Jane would suffer major bleeding and could die in a matter of minutes. Attempts to tie off the arteries and stop the bleeding could damage Jane's ureter and her kidneys. If time allows, the doctor might be able to hurriedly complete a hysterectomy, but then Jane would never again conceive and bear a child. Cutting into the cervix can also damage glands which play a role in a woman's ability to become pregnant. These glands secrete a mucus that helps transfer sperm. If damaged, a woman's fertility is compromised. Another problem with harming the cervix is that Jane could be left with a condition called "incompetent cervix". In this condition, the cervix is too weak to support the increased pressure

of a growing pregnancy, and it is generally not possible for a woman to carry a pregnancy to term. Possible treatments include total bed rest or the surgical closing of the cervix, although this procedure has limitations. An incompetent cervix may not be diagnosed until after a woman suffers a miscarriage or has premature labor and delivery. In Jane's case, suffering a miscarriage of a nonviable fetus the compression of the skull to allow it to pass the cervix is probably the safest option. It would be medically and morally wrong to disallow a procedure that may be the final resort to protect Jane's life, her health, her fertility, and her future child-bearing. LB 23 makes no distinction between a fetus that is viable or nonviable. It does not account for the many things that can go wrong in a pregnancy. It does not account for the complexities and variety of situations to which doctors must respond with their full arsenal of options. There will be situations such as Jane's. It would be a tragedy beyond words if this Legislature, through the threat of criminal prosecution, forced doctors to engage in medical procedures that could so seriously harm a woman like Jane, who is suffering a miscarriage [p. 6420] of a nonviable fetus. We cannot discount the real potentials of this legislation, which could lead to a woman's death, irreparably damage her health, make her sterile, or endanger her ability to carry future pregnancies. I urge you to adopt my amendment.

* * *

[p. 6422] SENATOR LANDIS: Thank you, Mr. Speaker, members of the Legislature. It is an irony because what Senator Schimek is reminding us of is that a woman may well want to preserve her fertility. Her life

may not be at stake, but she may want to [p. 6423] preserve her fertility, and this may be . . . it may bear on that outcome. And it will be interesting to hear why the Right To Life movement would be in opposition to allowing a woman to protect her continued fertility. I will tell you that Kansas did something recently and I think that it's something that we ought to think about. Kansas had a vote in their Senate, recently . . . it was 39 to nothing on this issue, 39 to nothing. It's the only one like it around the country that I know of. And you know what they did? They compromised. Nobody else does. Everybody gets pushed to the wall. Everybody's . . . whoever has got the votes wins the issue. In Kansas, they did their own work, and they said that they would ban all abortions after viability or after the fetus reaches the gestational week of 24 weeks, and that an exception could be made if two doctors, two doctors, determined that an abortion would be necessary to save a woman's life or to prevent the serious risk of substantial and irreversible impairment of a major bodily function. The measure would also outlaw partial-birth abortion unless necessary to save a woman's life. The bill is pending in the House Judiciary Committee. In other words, it is possible to fashion compromise. I doubt if we'll do it here. In fact, the proponents of the bill are prepared to allow a woman's fertility to be placed on the altar of the political agenda and to be forsaken. To take it out of the private domain of her decision-making, along with her doctor, and to make it an object in a greater cultural war between those who want to use the government, to use its power and its ability to coerce to win the choice-life fight that's out there. And one of the casualties of that is a woman's fertility. It must be ironic.

It's an irony I can't appreciate myself, being a man. If I was a woman sitting at home watching the Legislature, listening to David Maurstad and myself trade barbs in exchanges and speeches and to find that the green copy of this bill will basically say, if the choices between the political agenda of the proponents and the fertility of that woman whose watching . . . it's not her decision, it's our decision, and if we have the majority rule . . . it does not have a sufficient ethical gravity. It does not have a sufficient moral imperative to counter the proponents and their desire to pass this bill in its current form. I support the Schimek amendment. And those who watch us on TV, I think, need to see that this is the kind of problem that we get into when these bills are used to pass the morality of, in this [p. 6424] case, probably a majority over the objections of a minority.

SENATOR WILL: One minute.

SENATOR LANDIS: And that they're prepared to sacrifice the fertility of women to create a political victory to pass a law to effectuate this end. There is lots of heartbreak in the decision to have a child or not. And there's heartbreak whether you carry it to term or whether the child has so sufficient of a medical problem that the parent's choose, for the sake of their marriage, the sake of their other children, the sake of the woman's fertility, to abort the fetus. It's just not up to us. We are bad arbiters of that heartbreak. We are poor vessels for this decision. It is too intimate, too personal, too multifaceted to allow itself to be captured in the green copy of a bill and to say, we've got it right, . . .

SENATOR WILL: Time.

SENATOR LANDIS: . . . and we solved the problem of where the human misery is here and we know best. We don't. Fertility is too important to be sacrificed to this political agenda.

SENATOR WILL: Thank you, Senator Landis. Senator Maurstad, on the Schimek amendment.

SENATOR MAURSTAD: Thank you, Mr. President. I oppose . . . I stand to oppose the Schimek amendment. I've passed out to you a blue handout that goes through this particular argument and situation dealing with the health of the mother and the argument of threatening future fertility. It's been mentioned . . . I'll emphasize that I'm not a physician. That's correct. I'm asking that my colleagues look at the information that's been provided by physicians. There's been a lot of misinformation that has been developed as a result of this discussion at the federal level, and also throughout the country. As a result, a physician's group has been formed independent of any other pro-life or pro-choice groups that are trying to provide valid medical information to policy-makers as we continue to look at this circumstance. I draw your attention to it. Nancy Romer, M.D., Clinical Professor, Wright State University. In an article . . . "Medical Nonsense" of August '96. I'll read from it: [p. 6425] "There is simply no data anywhere in the medical literature in regards to the safety of this procedure. There is no peer review or accountability of this procedure. There is no medical evidence that the partial-birth procedure is safer or necessary to provide comprehensive health care to women." It goes on. Another . . . Lewis Moralo; Chairman, Department of Obstetrics and Gynecology, St. Clare's Hospital: "The conversion of a fetus presenting as

a vertex to a breach position, as in the partial-birth abortion, is capable of causing an abruption of the placenta and amniotic fluid embolism. This is a dangerous and life-threatening situation. Surely it would not benefit an already sick mother. Partial-birth abortion is major surgery and is extremely harmful to both mother and child. Never, ever, in our 30 years of practice, have I or my colleagues seen a situation which warrants the implementation of the partial-birth abortion. Personally, I cannot imagine why any practitioner would want to resort to such barbaric techniques when other recognized methods are available." It goes on. Another physician, in testimony before the Legislature, our Legislature's Judiciary Committee, February 12: "I think it's important to realize what this procedure . . . ", Paul Hays, M.D. "I think it's important to realize what this procedure asks of us as doctors to do possibly as many as three very risky procedures. One is the dilation of the cervix itself, manually, before it is time for that to occur on it's own, and that runs a risk for pre-term labor in the future. Also, the instrumentation. Putting sharp instruments into a woman's uterus blindly runs the risk of uterine perforation. And the very procedure of reaching into a woman's uterus, turning the baby from a head-first position to a feet-first position is literally prescribed against . . . literally prescribed against by my college of obstetricians and gynecologists. It's forbidden by the *Williams Obstetrics and Gynecology* textbook as being to [sic] entirely . . . as being entirely too risky for many different medical complications that occur." I could go on. It's on your desk. You can go ahead and look at it at your convenience. The situation is, in fact, the partial-birth

abortion causes, as described here, more problems for a woman's fertility, raises the risk of a problem with women's fertility. So the purpose of this amendment I can't agree with for the very reasons that the physicians that understand . . .

[p. 6426] SENATOR WILL: One minute.

SENATOR MAURSTAD: . . . this subject a lot better than I do [sic] have articulated. So I rise in strong opposition to this amendment. In fact, this procedure is dangerous. I don't think that there's anything that can justify the use of this procedure, and as a result urge my colleagues to vote against the Schimek amendment.

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[p. 6436] CLERK: Mr. President, the . . . next amendment, Mr. President, is by Senator Chambers. Senator, floor amendment 251. (FA251 appears on page 1901 of the Legislative Journal.)

SENATOR CHAMBERS: Thank you. Mr. Clerk, I appreciate that. Members of the Legislature, I'm going to tell you what this amendment does, and for the record, I will read the places where it will occur in the bill. At page 3, lines 14, 18, 24, 26. At page 4, line 3. At page 6, line 10. I would strike [p. 6437] "partial-birth abortion" and insert "intact dilation and extraction". What I think we ought to do is at least use the proper medical terminology. If we were dealing with any other procedure, as I had touched on earlier, we would not, in the statute, put pejorative, imprecise, nonmedical terminology as a substitute for the name of a medical procedure. Let me ask Senator Maurstad a question.

SPEAKER WITHEM PRESIDING

SPEAKER WITHEM: Senator Maurstad, will you respond?

SENATOR MAURSTAD: Yes, sir.

SENATOR CHAMBERS: Senator Maurstad, are you aware that this procedure that we've been discussing is referred to in the medical community as "intact dilation and extraction"?

SENATOR MAURSTAD: Senator, and I . . . I don't want to be evasive . . .

SENATOR CHAMBERS: Let me ask it a different way.

SENATOR MAURSTAD: Yeah.

SENATOR CHAMBERS: Do you think the insertion of this term would change what the bill is designed to do?

SENATOR MAURSTAD: Yes, I do.

SENATOR CHAMBERS: Tell me how you think that would happen.

SENATOR MAURSTAD: Well, first of all, Senator, the terminology that you propose is not in any . . . is not a medically accepted term either. It is used by those that perform abortions, but is not medically recognized itself.

SENATOR CHAMBERS: Let . . .

SENATOR MAURSTAD: I think that "partial-birth abortion", as it . . . as we use it and as it is defined, is clearly understood and can thereby be enforceable.

[p. 6438] SENATOR CHAMBERS: Senator Maurstad, are those who perform abortions, I mean legally now, . . .

SENATOR MAURSTAD: Correct.

SENATOR CHAMBERS: . . . are they physicians?

SENATOR MAURSTAD: Yes, they are.

SENATOR CHAMBERS: Are they members of the medical community?

SENATOR MAURSTAD: Yes, they are.

SENATOR CHAMBERS: If the term "intact dilation and extraction" is used to a group of physicians, even if they're all against performing abortions under all circumstances, would they know what that term means?

SENATOR MAURSTAD: Not necessarily, because it is not defined in any standard medical textbook or database.

SENATOR CHAMBERS: So you think when I use this term, nobody . . . you don't know what I'm talking about either?

SENATOR MAURSTAD: I'm saying that it could be misunderstood as to what it means. Even in the abortion community, D and E and D and X are used interchangeably, and they're not the same, and so . . .

SENATOR CHAMBERS: I'm going to ask you the question again. If a physician were to walk into this room, unaware of our discussion, and I were to ask the physician, what does intact dilation and extraction mean,

you're telling me that that physician wouldn't be able to tell me? The physician, in your view, would say, well, that's a term that has no medical definition and I don't know what you're talking about?

SENATOR MAURSTAD: No. No. There would be physicians that would be able to give their definition for it. But as far as using it as a reference in a court of law, it is important that we use a term that has and is understandable.

[p. 6439] SENATOR CHAMBERS: All right. Then let's use the term you selected. You already on this floor described it as meaning something different from what it says.

SENATOR MAURSTAD: No, sir, I did not.

SENATOR CHAMBERS: Partial . . . yes, you did. You said, when all of the child has emerged except for the head. You said that, and if you forgot it, I'll get the transcript.

SENATOR MAURSTAD: No, I did say that, and I also followed it up by saying that that was an accurate example of the definition provided in the bill.

SENATOR CHAMBERS: But that's not what the definition says, is it?

SENATOR MAURSTAD: It is not the only example.

SENATOR CHAMBERS: No, come on.

SENATOR MAURSTAD: But it is an accurate example.

SENATOR CHAMBERS: Now stop being evasive.

SENATOR MAURSTAD: I'm not.

SENATOR CHAMBERS: Now you are being evasive.

SENATOR MAURSTAD: No. Now, I don't . . .

SENATOR CHAMBERS: Read . . .

SENATOR MAURSTAD: I don't . . .

SENATOR CHAMBERS: Read . . .

SENATOR MAURSTAD: I don't mean to be.

SENATOR CHAMBERS: Read the definition for me.

[p. 6440] SPEAKER WITHEM: Senators, both of you. This discussion back and forth is an appropriate way of debating bills, but it's important that the senator, I think, who has the floor be able to ask the questions and then the individual be given an opportunity to respond. So, continue, Senator Chambers.

SENATOR CHAMBERS: Thank you, Mr. Speaker. Senator Maurstad, to give you an opportunity to continue, read the definition of "partial-birth abortion" for me, if you will?

SENATOR MAURSTAD: "Partial-birth abortion means an abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery."

SENATOR CHAMBERS: Now, what does "partially" mean?

SENATOR MAURSTAD: Senator, I . . . "partially" means a part of.

SENATOR CHAMBERS: But it doesn't mean as much as what you stated in your earlier description.

SENATOR MAURSTAD: It could mean . . . if I could respond.

SENATOR CHAMBERS: Okay. Go ahead.

SENATOR MAURSTAD: Can I respond?

SENATOR CHAMBERS: Yes. Yes.

SENATOR MAURSTAD: It could mean . . . "partially" would mean everything up to completely.

SENATOR CHAMBERS: It . . . so it could mean one thing and it could mean something else.

SENATOR MAURSTAD: There are many, many definitions of many examples that could fit in to the definition of "partially".

SENATOR CHAMBERS: So there is not one single definition. Is that what you would say?

[p. 6441] SENATOR MAURSTAD: That's correct, but . . .

SENATOR CHAMBERS: Okay.

SENATOR MAURSTAD: . . . "partially" would be the opposite of "completely".

SENATOR CHAMBERS: Okay. And you think that the language that I'm offering would confuse people,

it would lack precision, and there are people who are in the medical profession who would be incapable of saying what this means, even though there is a definition for it in the statute?

SENATOR MAURSTAD: I don't . . .

SENATOR CHAMBERS: If you defined this term . . . let me ask you this: Do you think the definition that you have placed in this bill, pursuant to the language given to us by National Right To Life, if you used the term that I'm suggesting and attached the definition that is in the bill, are you telling me that that definition does not define the term that I'm talking about? Is that what you're telling me?

SENATOR MAURSTAD: Yes, that's what I'm telling you, and if . . . I'll give a slight explanation on it, if you . . . I don't know how much time you have left.

SENATOR CHAMBERS: Then let me ask you this: What . . . based on your understanding, what does the term that I'm talking about mean to those who understand it? What does it mean?

SPEAKER WITHEM: Senator Maurstad, can you respond to that?

SENATOR MAURSTAD: Yes, sir, Mr. Speaker. Intact . . . I don't have your amendment right in front of me, I want to be . . .

SENATOR CHAMBERS: "Intact dilation and extraction". The term.

SENATOR MAURSTAD: My definition or my explanation of what "intact dilation and extraction"

would mean the procedure. Mr. Speaker, I going to have to . . . I don't know how much time he has left, but to give him . . .

[p. 6442] SENATOR CHAMBERS: Take it.

SENATOR MAURSTAD: Senator, to give you an explanation I'm going to have to go through the information that I've provided and it is on the record in General File as to what "partial-birth abortion" is and what could be another term of it could be "intact dilation and extraction". It is the partial removal of a child, and at that point in time, when we're talking about an abortion, it would be the killing of that child and then the extraction of it. The further delivery.

SENATOR CHAMBERS: So you know what the term means?

SENATOR MAURSTAD: As you know what the term "partial-birth abortion" means, Senator.

SENATOR CHAMBERS: Well, actually, I thought I did until I heard you tell me there are these different meanings of it. So what's in the bill is what we can't agree on, and you're not even precise on it because, Senator Maurstad, it's an imprecise term. The fault is not in you. You discussed the term the way anybody would have to discuss it. It is not a precise term, or do you think that it is?

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: "Partial-birth abortion" to me is a precise term that is plain and easily

understood by those that would need to comply with the statute, and that's what's important.

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TRANSCRIPT PREPARED BY THE
CLERK OF THE LEGISLATURE
Transcriber's Office

May 14, 1997

LB 23, 660A

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[p. 6751] CLERK: LB 23, Madam President, has been discussed on Select File. Enrollment and Review amendments have been adopted. Senator Brown had an amendment that was adopted. When the Legislature left the bill, yesterday, Senator Chambers had offered FA251. Senator, that amendment is on page 1901 of the Journal.

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[p. 6754] SENATOR CHAMBERS: So, I am saying, in my amendment, that you ought to at least call this procedure by a name which is more appropriate than . . .

SENATOR CROSBY: Time.

SENATOR CHAMBERS: . . . partial-birth abortion.

SENATOR CROSBY: Thank you, Senator Chambers. We do have a Doctor of the Day today. Dr. Reynen from the 25th District, Senator Warner's district, but I don't see him at the moment. But he is here. Also, Senator

Janssen has 44 fifth graders as his guests today from Lincoln Elementary in Fremont, Nebraska. (Introduced teachers.) They're in the north balcony. Would all of you please stand and be welcomed by your Legislature. Thank you for being here. Discussion on the Chambers amendment. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Madam President. I rise in [p. 6755] opposition to the Chambers amendment. Excuse me. On General File, we went through the process of providing, for the record, what the definition of a partial-birth abortion would be . . . as in LB 23. So I'm not going to go through that whole definition again because that's already been provided. The bill adequately defines partial-birth abortion. The terminology needs to be clearly and precisely descriptive of the action that is to be forbidden. Partial-birth abortion does that. There is not consensus among abortion practitioners, what to call this procedure . . . it's been called "dilation and extraction", it's been called "intact dilation and evacuation", the Chambers amendment would call it "intact dilation and extraction". In the media and the press through this whole discussion, those terms have been used interchangeably. As a result, it would not- . . . the description that is being used and proposed by Senator Chambers would not satisfy the requirement necessary in criminal law to be precisely descriptive. It is, in fact, a pseudomedical jargon. There's no terminology in any textbooks, medical textbooks that refer to this language. And so for those reasons, in addition to that it is plainly described in the bill itself, I oppose the Chambers amendment, would ask my colleagues to vote against the Chambers amendment. Thank you.

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[p. 6760] SENATOR ABBOUD: Thank you, Madam President. Would Senator Maurstad yield to a question?

SENATOR MAURSTAD: Yes, Madam President.

SENATOR CROSBY: Senator Maurstad, will you respond?

SENATOR MAURSTAD: Yes, ma'am.

SENATOR ABBOUD: Senator Maurstad, I had . . . this is more of a definitional question. I have one particular question. In the language on the committee amendment which we're on right now on page 3, lines 14 through 17 where it describes the partial-birth abortion, defines it . . . it means: "An abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child [p. 6761] and completing the delivery." I've . . . I think like most of us here, we've heard a lot about these partial-birth abortions and what exactly . . . what are exactly . . . I'm trying to figure but what exactly they are in that this definition appears to be a situation that would apply under current law. If a child is born, a child's alive, and then the child is killed, that appears to me to be murder or manslaughter or . . . you know, it'd be one of those definitions in which a person takes another person's life. And how would . . . how is this different than what the current law is with this type of a procedure?

SENATOR MAURSTAD: Senator, I believe what is at issue is whether or not . . . when that child is fully delivered or not, or at what point in time the child

receives the status that you refer to where infanticide or murder, as you referred to it, would be the . . . would be the issue. So what the point of all of this is that you have a circumstance where it's unknown what in . . . by current law, what the legal rights of that partially-born child would be, and that's one of the purposes for this legislation, I believe, is to make sure that this particular procedure doesn't occur.

SENATOR ABBOUD: Let me ask, maybe, a more specific question. In trying to define this, I understand that this is kind of the crux of the bill here. Where I think a couple of the key terms are the "partially delivers vaginally". What does that mean? Or what's your- . . . what's your feeling . . .

SENATOR MAURSTAD: That means that the . . .

SENATOR ABBOUD: . . . as far as the definition of that?

SENATOR MAURSTAD: . . . living unborn child is not completely delivered from the vagina.

SENATOR ABBOUD: Um-hum. Well, what does that mean. I don't understand. Does that mean that the child is outside the body of the mother or does that mean that the child is still inside?

SENATOR MAURSTAD: Part of the child is outside of the mother and part of the child is not.

[p. 6762] SENATOR ABBOUD: Okay. And when we say "a living unborn child", how do you define that?

SENATOR MAURSTAD: A living unborn child?

SENATOR ABBOUD: Um-hum.

SENATOR MAURSTAD: "Unborn" would be . . . would mean that the child is not completely delivered or outside of the mother. "Living" is living. It's the opposite of death.

SENATOR ABBOUD: I think . . .

SENATOR MAURSTAD: I'm trying to be as clear as I can.

SENATOR ABBOUD: I understand that.

SENATOR CROSBY: One minute.

SENATOR ABBOUD: I just . . . I think you ought to realize here that we're talking about prosecuting these people under a Class III felony and when they're looking . . . when we're looking to prosecute these people . . . I think this bill is going to pass like Senator Chambers has stated earlier, and I do support this bill and I plan on supporting it. But when this . . . when the law hits the reality of the prosecutors around the county . . . around the state, start prosecuting individuals who perform these types of operations, I think we need to provide additional guidance as to these definitions to properly prosecute and convict these individuals, or else I think you have some problems with the bill. And I'll discuss this with you off the floor, but I think, probably, in the legislative history there should be some further definitions on this, and maybe there is nothing more that

you can provide from what you've described to me, but I did . . .

SENATOR CROSBY: Time.

SENATOR ABBOUD: Thank you.

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[p. 6763] SENATOR SCHIMEK: Senator Maurstad, I'm not very . . . I'm really not very certain of some of these medical terms that I've been reading about and I'd like to clarify a little bit more, if we could, the . . . your understanding of what a partial-birth abortion means. And as I understand it, there are two different kinds of procedures and one is called the "intact D&E" or the "D&X" as it's referred to in some literature, and then there is the "D&E". And I am wondering if partial-birth abortion refers to both of those procedures. Now I heard you say, earlier, when Senator Chambers was asking questions, that this referred to an intact D&E. Is that correct? Is that your understanding.

SENATOR MAURSTAD: No, I don't believe I did say that. I think that what I indicated was in the press that it has been referred and described in a number of different ways. If I could . . .

SENATOR SCHIMEK: That's the problem, Senator Maurstad. I don't think there's a clear understanding of what this terminology means and I agree with Senator Abboud that there might have to be, at least, some discussion for the record of what we're really talking about here. So could you elaborate a little bit?

SENATOR MAURSTAD: Yes, Senator Schimek, Madam President. I can go through what my opening of

General File again where I described, for the record, what I meant by a partial-birth abortion if you would like me to do that. I can secure . . .

SENATOR SCHIMEK: Could you . . .

SENATOR MAURSTAD: I can secure that . . .

SENATOR SCHIMEK: Could you give me a one sentence . . .

SENATOR MAURSTAD: The . . .

[p. 6764] SENATOR SCHIMEK: . . . or two sentence definition, Senator?

SENATOR MAURSTAD: No, probably not. That's the whole issue. The terms that have been used, "intact dilation and evacuation", "extraction" . . . you know, they may have a broader or more restrictive definition than what is in the law itself, and that's why I provided on General File, and I can go through the description again of what I believe a partial-birth abortion is.

SENATOR SCHIMEK: Well, Senator Maurstad, if you can't give it to me very . . . in a very compact style, I'll get the transcript from the testimony that you gave on General File and I'll look that over and see if it's any clearer to me. But I'm not sure that that's going to . . . I mean, it seems to me for the average OB/GYN out there, they might need some clarity in the statute.

SENATOR MAURSTAD: Well, if you want me to take your time, I will go through what it is again.

SENATOR SCHIMEK: No, no, no. I mean in the statute itself.

SENATOR MAURSTAD: Okay.

SENATOR SCHIMEK: They're not all going to have the time to read the record of . . . or the transcript of what we say here. I'm just thinking in practical and legal terms here. The other thing is . . . I'm wondering . . . I have become aware, since we were on the last bit of debate that we did on this, that there was a case in Ohio that provided some injunctive relief and prevented Ohio's bill from being enacted . . . or implemented, I should say. It was enacted, but it was implemented, and that case has been appealed to the Sixth Circuit, I believe, and that was heard this month, if I'm correct in my information.

SENATOR CROSBY: One minute.

SENATOR SCHIMEK: And that decision hasn't been handed down yet. But the implications were that this procedure which we call "intact D&E", or whatever we call it, could not constitutionally be prohibited. And . . . you don't have time to answer that now, but maybe you'd like to do that on your own time, or, my time [p. 6765] later on. Thank you.

SENATOR CROSBY: Thank you, Senator Schimek. Senator Witek, on the Chambers amendment. Senator Witek. I don't see Senator Witek. Senator Maurstad, your light is next. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Madam. President. I think some of what I was going to say when I turned my light on I've already said relative to the aspect of the meaning. I think the meaning is very clear. I think anyone that wants to sit down and objectively look at

what Section 9 . . . subsection (9) of Section 2 means, understands that we're talking about a procedure where "a person performing the abortion partially delivers . . . ", I think people know what"partially" means and what "delivers" means, " . . . vaginally a living unborn child." I believe that people understand and know what that is. I believe that the language is very clear. I will provide for Senator Schimek my comments on General File while I provided what I felt was the definition for guidance for those that would look into the record for that . . . for that direction and guidance, which I think is important. But even so, I think that the way that the language is in the bill is clear and it [sic] understandable and once again would reiterate . . . ask my colleagues to vote against the Chambers amendment.

* * *

[p. 6767] SENATOR CHAMBERS: Thank you, Senator Kiel. Madam President, members of the Legislature, for something which is so clear, Senator Maurstad and Senator Witek are finding it to be an impossible task to explain what it is that is so clear. He keeps saying people know and understand what this language means, but he doesn't know and understand what it means. He keeps saying the language is very clear, and I noted this as he said it. But he keeps wanting to refer you to the record and what was said on General File, which I will conclude, since I was not here to listen, that he must have read something that somebody else stated, so he doesn't know. But one thing I want to make everybody understand, and I'm glad Senator Abboud brought it up, when you look at the criminal law you cannot go outside of

what is written in that law for the purposes of prosecution. And the criminal law is always strictly or narrowly construed. The court cannot infer anything, it cannot extend the actual words to encompass something that is not clearly encompassed by those words. If there is any ambiguity in a criminal statute, it's struck down as unconstitutional. And the courts have ruled so many times in this area that I'm surprised that the legal staffs of some of these people haven't told them that. A person must be clearly apprised of what conduct is allowable and that which is prohibited. And if there is any ambiguity in the statute, the statute is struck down. If there is ambiguity in the document used to charge a person, whether it's in information and indictment, a complaint, that complaint is dismissed. Ambiguity always is resolved in favor of the accused. So if you're going to look at the record at all, you will see that those who are bringing this bill don't understand it. They remind me of a song that Harry Belafonte sang. It went something . . . and I'm not going to sing it, when I was a lad, just three foot three, certain questions occurred to me. So I asked my father, quite seriously, to tell me the story about the bird and the bee. He stammered and he stuttered pathetically, and this is what he said to me. He said, the woman Piaba, the man Piaba, the cane stand tall like the lemon grass. The lily root, gully root, belly root, ummm, And the [p. 6768] famous gunny scratch, scratch. And the little boy says, and this is what I say about their definition, it was clear as mud, but it covered the ground, and the confusion made me brain go round. So I grabbed the boat and I went abroad, and in Baden, Germany met Sigmund Freud. He said, son, from your sad face remove

the grouch, put the body upon the couch. I can see-from your frustration a neurotic sublimation. Love and hate is psychosomatic, your Rorschach shows your [sic] a parapatetic. It all started with a broken sibling in the words of the famous Rudyard Kipling. So then the little boy says again that it was clear as mud, but it covered the ground, and so forth. So then he says . . . well, I probably don't have enough time to give you the next stanzas. I will do that if I get a chance. But the point I'm trying to make is this, people, rather than being able to convey to us the meaning of these terms, will do a lot of talking and say a lot of words which only obscure, and they want it to seem as though they have said something meaningful, when they haven't. If Senator Maurstad does not know what he said and cannot repeat it for the record now but must say, go back to what I said on General File, it means that he doesn't even know . . .

SENATOR CROSBY: One minute.

SENATOR CHAMBERS: . . . what he said. He does not know what these terms mean, and he understands that they're imprecise. Mine, my amendment would lend a measure of precision that his lacks. So, as I stated, they cannot accept my amendment, and I know it. But by virtue of the fact that they deliberately want to retain an obviously ambiguous term, the meaning of which they don't know, over a term that brings more certitude in the case that they want to inject into the statute "unclearness" as a trap for the unwary.

SENATOR CROSBY: Thank you, Senator Chambers. Senator Schimek.

SENATOR SCHIMEK: Thank you, Madam President, members of the body.

SENATOR CROSBY: Senator . . .

SENATOR SCHIMEK: This, frankly, is a very difficult issue and a [p. 6769] very upsetting issue. And I am sorry to prolong the discussion. But, Senator Maurstad, I'm still not clear on your definition. In your opening statement it indicates that this procedure involved the suctioning of the baby's brain. And according to what I have read, in the *Voinovich* case, that refers only to the intact D&E procedure. It does not . . . it does not refer to the . . . the D&E procedure that does not leave the baby intact. And I want to know if your definition . . . what your definition includes for sure. Senator Maurstad, would you be willing to answer the question?

SENATOR CROSBY: Senator Maurstad, Senator Maurstad.

SENATOR MAURSTAD: I apologize, Senator Schimek, I didn't realize you were going to ask me a question. I thought you were making a statement, so I was on the phone. If you could re . . .

SENATOR SCHIMEK: That's all right. Let me ask it very simply. Your statement talks about the suctioning of the babies brain. If the procedure does not involve that, is that referenced then under this statute? And I apologize for bringing the graphics into this, but all I'm trying to illustrate is I don't think this is a definition that will legally stand the test.

SENATOR CROSBY: Senator Maurstad.

SENATOR MAURSTAD: Senator, I'm trying to cooperate. But I need to understand what your question is. You answered . . . I mean you end up making a statement. I don't know if you want me to respond to your statements or . . . I mean . . .

SENATOR SCHIMEK: Which ever you prefer, Senator Maurstad.

SENATOR MAURSTAD: Okay. Well, I would indicate that the definition that is in the law that would provide the guidance is easily understood, that the terminology is clear.

SENATOR SCHIMEK: Well, then I . . .

SENATOR MAURSTAD: I know what this means. I think you know what this means when we talk about partially delivers vaginally a living, unborn child before killing the unborn child and [p. 6770] completing the delivery. I think you know what that means.

SENATOR SCHIMEK: All right. Then let me approach this another way, Senator Maurstad. Does it refer to a nonviable fetus?

SENATOR MAURSTAD: There is no reference in the definition to viable or nonviable.

* * *

[p. 6771] SENATOR WITEK: Thank you, Madam Chairman, members of the Legislature. I'm just going to read a little bit from the Congressional to try to clarify, because it's very clear to me, but I want to make sure that no one is being confused by this discussion. We're talking about a new category, we're talking about

children who are partially born. Prior to this discussion and the abortion decisions, they talked about unborn children, that's in all the statutes, unborn children, all the case law, everything that they've talked about. We also talk about children who are born. We have statutes that cover these children who are born. What we do not have is children who have been partially born, and that's why we came in with LB 23 this year, Senator Maurstad, because we have to go into this area of the partially born child and discuss how we want to handle this specific procedure where a child is delivered partially, the head or whatever portion is still within the mother, and they puncture the base of the skull and suction out the brain of the child, it is that procedure. The reason it doesn't have a specific medical procedure, Senator Maurstad has handed that long ago onto our desks. And I hope those people who are confused have looked this over. It talks about the . . . there is no consensus, even among the abortion practitioners about what they call this procedure. One doctor calls it a D&X, another calls it a D&E. When the partial birth abortion ban was enacted, or was written in 1995, neither the D&X, nor the intact D&E appeared in any medical dictionary or in any medical data base, nor did either term appear in the textbooks on abortion methods, abortion practices by late -term abortionist, specialist, Dr. Warren Hern. What we're talking about is a legal term, that's why we use partial-birth abortion, because we have to go into the area of the legal term. These terms, D&X or intact D&E, originated as a kind of pseudo-medical jargon, which should not be employed in criminal law because of the risk that courts will declare that the law to be void on vagueness. Partial-

birth abortion was chosen to satisfy the requirement that criminal laws must be precisely descriptive of what is forbidden in order to pass constitutional muster. And that's the discussion that Senator Chambers is trying to raise, wrongly I say, because this is very graphically described a number of times in debates, both on the floor of Congress and here and in testimony in front of the Judiciary Committee. I think it is [p. 6772] very clear the procedure that we are trying to discuss and to ban in the state of Nebraska. It's been thoroughly discussed. And I think if . . . maybe it's just that people need to look again at the information that Senator Maurstad has provided to us on the floor and read that over again and see that this is written very well and precisely so. It will be able to encompass any of the medical jargon that may be out there. And that's why Senator Maurstad has chosen the specific term of partial-birth abortion. So it is a new category, not unborn, not born; but a partial-birth. And that's why we need to do this in the first place. Thank you.

* * *

SENATOR CHAMBERS: Thank you, Senator Schimek. Madam President, members of the Legislature, every time Senator Witek or Senator Maurstad tries to tell us how clear this is, they have to read something which they don't even understand. She doesn't even understand what she was reading. And then she said, I want to read this so that it's clear to everybody and nobody on the floor is confused, or something to that effect. She's confused. She cannot even paraphrase what she read. She trots in and out as they give her stuff to read, and they probably say, now preface this with this is so clear that a

fool cannot err. Then she has to read it and doesn't know what it meant.

* * *

[p. 6773] Senator Witek, in which dictionary will I find a definition of partial-birth abortion?

SENATOR COORDSEN PRESIDING

SENATOR COORDSEN: Senator Witek, would you respond to a question, please.

SENATOR WITEK: I would say at some point in time, after we [p. 6774] determine this bill, it will be in the dictionary, probably in every dictionary.

SENATOR CHAMBERS: No, I'm asking, where is it now?

SENATOR WITEK: The whole reason for having this discussion, Senator Chambers, is because at this point in time we have . . . we have law on an unborn child and a born child, but we don't have the partial-birth discussed.

SENATOR CHAMBERS: I know it's hard for you to understand English, but I'm going to try again. Is there a definition . . .

SENATOR COORDSEN: One minute.

SENATOR CHAMBERS: . . . of partial-birth abortion in a dictionary that you know of?

SENATOR WITEK: There is a definition for partial, there is a definition for born, and there is a definition for abortion.

SENATOR CHAMBERS: Well, born is not even a part of what we're talking about. I'm talking about birth. You . . .

SENATOR WITEK: There is a definition for all three of those words in the dictionary, Senator.

SENATOR CHAMBERS: Is there a definition of the term partial-birth abortion?

SENATOR WITEK: Senator, why would there be a definition in the . . .

SENATOR CHAMBERS: Thank you, Senator Witek. Do you see why it is so difficult here? She doesn't even understand the term that I'm asking her about. She doesn't understand what I mean when I ask her, is there a definition. lend [sic] she just got through yammering from something she read, and I told you she didn't understand it. They say, well there is no definition of ID&E anywhere, so I asked her, is there a definition of the term you're talking about? And she doesn't then know what the term, is there a definition, refers to. And she and Senator Maurstad [p. 6775] are the experts in the law who are going to tell us what these words mean, when they don't even know what it is they're talking about. It's preposterous.

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[p. 6784] SPEAKER WITHEM: Mr. Clerk, would you please call the roll on the adoption of the Chambers' amendment.

CLERK: (Roll call vote taken. See page 1979 of the Legislative Journal.) 11 ayes, 27 nays on the amendment.

SPEAKER WITHEM: The amendment is not agreed to.

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SENATOR KIEL: Broke. Thank you, Mr. Speaker and members of the Legislature. I am offering amendment today which would provide an exception to the prohibition of intact D&E, if a woman is at serious risk of substantial impairment of a major bodily function. This is language that is currently in state statute, you will find it in 28-326, under the definition of "emergency situation", which was adopted in 1993. And since most of you will probably not have it in front of you, I'll read the language in the statute. Emergency situation shall mean that condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death, or for which a delay will create serious risk of substantial impairment of a major bodily function. That's the language that's in the statute now, and that is why I'm now offering it as an amendment to this proposed bill. The reason I'm offering it as an amendment to this bill is based upon constitutional issues, that is a woman's health must be a consideration in the performance of an abortion. We, as a state, have included this exception partly, I hope, because we hold that a woman's health is vitally important. But I want to take this opportunity very briefly to address some claims and issues surrounding a health exception required under constitutional law. I will tell you that I find offensive claims that this exception includes, among other things, a woman hates being fat, a woman hates

giving birth, a woman just, hates [p. 6785] being pregnant, a woman considers that a pregnancy is interfering with her career goals, a woman hates being pregnant because she can't afford a baby and a new car, and that a woman has changed her mind, wanted one yesterday and doesn't want one today. These are outrageous claims, but they also confuse the matter when, in a pregnancy, the health exception becomes a factor under constitutional law, and under current Nebraska law. Prior to viability of the fetus, the state cannot ban abortion. After viability, which is roughly the third trimester, the state can and does ban abortion, except when necessary to preserve the life or health of a woman. To claim that a woman would seek an abortion in the third trimester of pregnancy for one of the reasons I just stated is a grievous insult to all women. Does anyone truly believe that in the seventh, eighth, or ninth month of pregnancy a woman would decide she wants an abortion because she hates being fat, or wants to buy a car? Can you imagine a physician who would jeopardize his or her career and livelihood by performing a third trimester abortion for these reasons? I can't imagine that. But, getting back to the health exception, a federal court ruled on the health exception in United States v. Voinovich, this was in 1971, two years prior to the U.S. Supreme Court Roe v. Wade decision, which made it very clear that a health exception was a constitutional must. In its 1973, *Doe v. Bolton* decision, the Supreme Court again protected the health exception, stating, the attending physician's best clinical judgment that an abortion is necessary should be sufficient. It went on with words I'm going to emphasize, "If a physician is licensed by the state, he is recognized by the state as

capable of exercising acceptable clinical judgment." Thirteen years later, in 1986, *Thornburg v. American College of Obstetricians and Gynecologists*, the high court ruled the law unconstitutional because it required "a trade-off between the woman's health and fetal survival and failed to require that maternal health be the physicians paramount consideration." The court not only ruled on the health exception in *Thornburg*, it addressed the primary question before us today, that question is, who will make the decisions about medical care, doctors or legislators? In *Thornburg*, the court ruled that when performing a post-viability abortion a physician must have the authority to choose the method most likely to preserve his patient's health, even if it might jeopardize fetal survival. More recently, in 1992, the court upheld the central ruling of Roe and Planned [p. 6786] Parenthood of Southeastern Pennsylvania v. Casey. And we cannot ignore, I think as Senator Schimek has mentioned before, an ongoing case, which is the *Women's Medical Professional Corporation v. Voinovich*. In 1996, the district court permanently enjoined an Ohio law, similar to this proposal. The matter is currently before the Sixth Circuit Court of Appeals. This should give us, I would think, pause for thought. There are some other cases on point that I will probably speak to later on in this debate. But one of the things I want to make clear is that the Supreme Court has been consistent and explicit on a health exception and has made it clear that doctors are vested with the responsibility to make medical determinations about a patient's care. I hope and trust that the Legislature will adopt language that's already in statute that will provide some protection or [sic] a woman's health. Thank you.

SPEAKER WITHEM: Senator Wesely, to debate the Kiel amendment.

SENATOR WESELY: Thank you, Mr. Speaker, members, I rise in support of the Kiel amendment. And I appreciate that she's willing to raise the issues that she is. I want to follow up on the previous discussion I started, dealing with the medical aspects of this issue. I continue to be concerned about the fact that we are dictating in here a medical procedure, again, recognizing that as it's been described, as most of us in the public see it, as an abortion procedure, as gruesome and objectionable, but there are other situations that apply that I want to follow up on, and again indicate that we're not dealing with just the aspect of abortion, but there are other situations where this legislation will apply. And how it will impact physicians in carrying out their medical duties has me concerned. Let me continue and follow up to another letter from a physician, again dealing with this issue. My concern with nonmedical personnel trying to dictate medical procedures includes telling a physician which procedure to use and how to do something. If there are three procedures, A, B, and C, and the decision is to do either A, B, or C, has to be made by a medically trained individual using the patients' age, health risk for infection and for hemorrhage. If you decide that C is not acceptable and make it illegal, you have limited physicians' choice and put a patient's health at risk. I do not try to make light of anyone's special training. I know my limitations, try [p. 6787] to depend on people that have the facts to educate me or do things for me that I'm incapable of doing. A person who decides to spend 12 years of post graduate training working 100 to 120 hours

a week to become a doctor requires hundreds and thousands of facts and hours of experience with which to make medical judgments. A spontaneous AB does not always involve a dead fetus. I would say before 12 weeks, 99 percent are dead. After 12 weeks the error becomes much greater, and this is my concern. The way the bill reads, if a woman would come in between 14 and 24 weeks with a premature labor and the cervix dilated, or an incomplete cervix with the cervix dilated, or with premature ruptured membrane, or a chorioamaniontis, we are faced with a pregnancy that we aren't able to save. In those cases it is best to go ahead and proceed with completion of what nature has begun. But by the definition of partial-birth abortion in your bill, if we have a heart rate and proceed, then we have to be . . . then we would be at risk for loss of our license, censorship, criminal charges, et cetera. The reason a physician would go ahead at this point instead of waiting for the baby to die is to decrease the risk of infection, therefore decreasing the risk of scaring of the uterus and tubes and causing sterility. To wait for the placenta to separate or partially separate so that the fetus bleeds to death and the mother, losing a lot of blood, possibly causing death or the need for transfusions, or the risks for hepatitis and AIDs is very distressing. Are we arguing over words that need to be changed, such as spontaneous, elective, incomplete, or induced? If an AB is started on its own, can the physician finish it to help prevent these medical complications for their patient as I've described? These incidents happen much more often than we would hope they would, and this is just not a patient or client to me, this is a person. It

is someone I am caring for. If it is your wife, your daughter, or your granddaughter, I am certain that you wouldn't want me to have my hands tied, not to be able to do the correct medical treatment. As I said before, law and writing bills is not my forte, but the way I read this bill as written it would prohibit us from taking care of patients in these tragic situations. Again, the concern is what are the implications beyond the particular situation that we've heard described previously about a live fetus being drawn forward and . . .

[p. 6788] SPEAKER WITHEM: One minute, Senator.

SENATOR WESELY: . . . this partial-birth, or the other terminology Senator Chambers had us look at, this procedure going forward. Personally, I plan on supporting LB 23 and the thrust of what they're trying to do. But I also think that being careful about the language, and I think Senator Kiel is trying to make this point, let's be careful about the language in the bill, has implications beyond the obvious, beyond the simple case that's being made. And we need to understand those implications. And I do hope that we will consider carefully what we're doing here, it has an impact beyond what I think we've discussed so far. Thank you, Mr. Speaker.

* * *

[p. 6790] SENATOR LANDIS: Mr. Speaker, members of the Legislature, I support the Kiel amendment. And, by the way, with it I think I would vote for LB 23. The issue should be when this, if this is going to be outlawed, and it's obviously going to be outlawed in this

state, if this is going to be outlawed, what are the exceptions. Unfortunately we have limited the life exception in a way that we've never limited the life exception before. There is also a standard practice in our statutes to recognize a set of concerns greater or more than simply the life of the mother, and those are included for health. Opponents of or supporters of this bill, rather, have always been concerned about the use of the word "health" because it implied mental and emotional stress and could be used in a wide variety of circumstances. Senator Kiel is asking not about that, what she's saying is losing an important bodily function, who among us claims the wisdom of a Solomon that can say a woman, by law, is to be denied a procedure that could maintain an important bodily function, and that, if we pass this law and we're going to outlaw the procedure, that we dictate, as a matter of law, that she lose an important bodily function? It is of concern to me that we take too much towards the end of our legal ability the moral authority to deny a woman here continuing fertility by law, the use of an arm, the use of a kidney, the use of a full lung capacity, whatever it might be, this loss of physical well-being. I know that we're trying to stop and the supporters want to stop a practice that they find brutal and horrific. But understand the cost at which you are doing that. And that's to say by law a woman has to give up her . . . an important medical and physical well-being simply because it doesn't rise to the level of life-threatening. It's okay if she loses a kidney, it's okay if she loses her fertility. This is beyond our ability to rule and judge and evaluate when we place into the scale of our own sense of justice the moral implications of the fetus and the moral

implications of the mother and her continuing fertility. This is not a place for us to act. This is a place for a woman, her doctor, her source of moral advice and counsel, the well-being of the family, this is not for 25 legislators to rule which parts of a woman's physical well-being must she surrender on the altar of politics and the cultural war agenda of the extreme right. This is not a place for us to act. I support the Kiel amendment. I know it will fail. Senator Chambers is [p. 6791] right. I see a letter here on the desk that says . . .

SPEAKER WITHEM: One minute.

SENATOR LANDIS: . . . . the Christian Coalition says no amendments. Those of you who get this letter, get your marching orders from the Christian Coalition, 23 with no amendments. We can't consider the notion of a woman's physical well-being, not emotional or even mental, but her physical well-being, and this body's prepared to sacrifice her fertility, the well-being of internal organs, her mental capacity, it could be memory loss, it could be reasoning loss, and we're prepared to do that in this body because LB 23 is to pass without amendment. That is itself horrific as well. Yes, what 23 talks about and tries to outlaw is a horrific phenomenon, but this is horrific as well. And we should not place ourselves . . .

SPEAKER WITHEM: Time, Senator.

SENATOR LANDIS: . . . into picking between these two choices.

SPEAKER WITHEM: Senator Maurstad.

SENATOR MAURSTAD: Thank you, Mr. President. I rise in opposition to the Kiel amendment, and I do that because, as we discussed earlier, there's overwhelming medical testimony insisting that partial-birth abortion is never medically indicated and can itself pose serious risks to the health and future fertility of the mother. I think that as I read and learn more about this I think you can say and I will say that this procedure should not be used for the very reasons that this amendment is being brought, that this procedure is in fact dangerous. And there are other more . . . less risky procedures that can provide an option to the mother. Now I . . . it's been indicated earlier there aren't any physicians in the body, I'm not a physician, but I believe it's important to go to individuals that have given testimony and see what they have to say about this particular procedure and whether it is medically necessary. The Surgeon General, former Surgeon General, Koop, publicly verified that there are no medical conditions, either maternal or fetal that require using partial-birth abortion to preserve the mothers' health or future fertility. There are [p. 6792] others that have provided testimony. And Dr. Harland Giles (phonetic), who performs second trimester abortions up to the point of viability, testified, I do not think there are any maternal conditions that I am aware of that mandate ending the pregnancy that also require the fetus be dead or the fetal life be terminated. There are those that were concerned about the fertility issue, that I think is in essence the heart of this particular amendment. Dr. Donna Harrison (phonetic), this is medical nonsense, there is nothing gentle about grasping the opening of the

womb and thrusting scissors inside to perforate a wiggling head. Indeed, any surgeon can tell you that when you put a sharp instrument, like scissors into a body cavity there is always risk of perforating that organ. As an obstetrician I can testify that this procedure has no medical indication over standard, recognized and tested procedures for terminating a pregnancy. Banning this procedure will in no way compromise the legitimate practice of obstetrics and gynecology. And there is other testimony that I have passed out, on the handouts to everyone, that continue this same overwhelming set of data and information by experts in this field that have indicated that there are other procedures that can be chosen, that this isn't needed, this isn't necessary, this is more risky, and as a result, I think, provides further evidence of the reason why we can in fact indicate that this procedure, as indicated under the *Casey* case, can be looked at and regulated by the state. I'm not an attorney. I'm not going to get into a constitutional discussion, I'll leave that for attorneys that can tread into that water more successfully than I can. But we've somewhat gone through this issue . . .

SPEAKER WITHEM: One minute.

SENATOR MAURSTAD: . . . thank you, Mr. Speaker. We've somewhat gone through this issue so, as I indicated before, in the spirit of not dragging this procedure on by being redundant, I would just say that again I'm opposed to the Kiel amendment. The overwhelming information and testimony that has been provided throughout the country indicates that partial-birth abortion is not needed, not medically necessary to preserve

the life or health of the mother, and as such should not be sanctioned in our state. Thank you.

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TRANSCRIPT PREPARED BY THE CLERK
OF THE LEGISLATURE
Transcriber's Office

May 20, 1997 LB 23, 271, 658, 752
LR 172-176

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CLERK: When the Legislature left the bill on May 14, Senator Kiel had an amendment pending. I have a note, Madam President, that Senators Brown and Maurstad have had a conversation with Senator Kiel and she wishes to withdraw and allow substitution, by Senator Maurstad, of AM2325.

[p. 7759] SENATOR CROSBY: No objections to the substitution? So ordered.

CLERK: AM2325, Senator Maurstad. (See pages 2157-60 of the Legislative Journal.)

SENATOR CROSBY: Senator Maurstad, to open on your amendment.

SENATOR MAURSTAD: Thank you, Madam President. Members, as sure everyone's aware, this is an issue that has been discussed throughout a number of legislatures across the state (sic) and . . . or across the country, in addition to it continuing to be pursued in

Congress. In fact, today there was a vote on this particular issue that received 64 votes, passing the amendment, bipartisan support, and including that of minority leader Senator Daschle. And what this amendment does is very similar to what occurred there in that it incorporates three items that the American Medical Association felt important that were and have been agreed upon that, in essence, allowed them and their legislative body to be supportive of HR 1122 in Congress. Now people will recall that the bill that I introduced was modeled after the legislation that is in Congress. The first question that might come up is, well, if it's passed the House and it passed the Senate, why do we need to proceed in Nebraska? And, quite frankly, that's because there is still an opportunity for that not to become federal law. With 64 votes, it is 3 short of an override if necessary, assume the bill is moving to the President and he has vetoed similar legislation in the past. So it's important we continue to move on. As I've indicated on General File in my opening and through the discussion, it's been my intent to focus on prohibiting a particular abortion procedure in the state of Nebraska, and I wanted that to be done as clearly as possible. I have agreed to go ahead and incorporate the changes that occurred at the federal level because I think they make the bill clearer, they make the definition clearer, and that has been a concern of the opponents of the legislation and I believe that it does that. I would first, I've handed out a number of different handouts . . . I would first indicate, draw people's attention to the letter from the AMA to Senator Santorum where, in the first paragraph, it indicates, although our

general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly [p. 7760] defined and not medically indicated. HR 1122 now meets both those tests, and I think that that's important 'cause we've had that discussion before and we've talked about that this is not a medically indicated procedural need. There are . . . I've also handed out a section-by-section description. The first section clarifies the language with respect to the license suspension and revocation, and ensures that the Health and Human Services Director of Regulation and Licensure shall make findings with regard to whether the licensee's conduct was necessary to save the life of the mother if a petition to suspend and revoke the attending physician's license to practice medicine is filed by an Attorney General. The second section clarifies the definition of the procedure. It further defines the term "partially delivers vaginally a living unborn child before killing the unborn child" to mean deliberate and intentional delivery into the vagina of a living child or a substantial portion thereof for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child. I think it is very clear now, as we've indicated in previous discussion on Select File, that this means that you have to have intent, so those issues revolving around miscarriage are cleared up in this particular . . . with this particular further definition. Section 3 of the amendment eliminates or preserves, excuse me, Section 3 preserves a physician's judgment to take any medically necessary steps to save the life of the mother

by removing that no other medical procedure would suffice for that purpose, another area that we had discussion on previously Select File that I believe should be acceptable to the opponents. And then the last section gives the . . . gives any accused physician the right to have his or her conduct reviewed by the Health and Human Services Director of Regulation and Licensure before a criminal trial commences. It indicates that he can go in and ask for a delay in the criminal trial until after the review by the Health and Human Services Director of Regulation and Licensure occurs. I would also like to draw your attention to another statement by the AMA which further indicates their support. Everyone will recall we've had discussion as to whether or not where physicians were. There has been, of course, the Physicians' Ad Hoc Coalition for Truth that have indicated very strongly that this procedure is not needed. In fact, their position is it's not medicine. The AMA now, through their legislative [p. 7761] process, are supportive of banning the partial-birth abortion. Paragraph two: "HR 1122", which LB 23 mirrors, "now narrowly defines the procedure to be restricted – a procedure for which AMA's expert panel could not find any identified situation in which it was the only appropriate procedure to induce abortion – and it broadens the exceptions." The changed language is in the bill now: "makes it clear beyond any question that the accepted abortion procedure known as dilation and evacuation, also referred to as D & E, is not covered by the bill; (b) permits the procedure to save the life of the mother without any obligation to show that no other procedure would suffice; and (c) does not restrict use of the procedure for physicians intending a delivery at the

outset." It can be done as necessary in their best medical judgment. Further in their statement, to clarify their position and support of the ban on partial-birth abortion: "As amended, HR 1122 is now a bill which impacts only a particular and broadly disfavored, by both experts and the public, abortion procedure. It is a procedure which is never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development." AMA's position goes on: "Indeed, the procedure differs materially from other abortion procedures which remain fully available, in part because it involves the partially delivered body of the fetus which is outside of the womb." Their statement continues: "HR 1122 is serving as a model for many state legislatures and is vitally important that the improvements which have been made become a part of the broader legislative process." And so that's why, with the . . . my staff's help, others' help, we have brought this amendment to you this evening to start the continued discussion on LB 23. I appreciate Senator Kiel's willingness to let a substitute because I think this, in fact, provides I believe needed clarification and hopefully will make the bill more acceptable to those that have not decided up to this point in time whether they can be supportive of LB 23.

SENATOR CROSBY: One minute.

SENATOR MAURSTAD: Thank you, Madam President. The . . . my last discussion I know that there, from what's occurred in earlier discussion, that there will be some that think that this language has already been offered. I would indicate that [p. 7762] there's certainly been discussion about more clearly defining it. Quite

frankly, when I heard that the AMA had some conditions I was skeptical as to what . . . what that was going to actually be presented. I was pleased to find that they've taken a very reasonable approach. I think it was reasonable for the Senate to include it in the bill that they adopted today, although three votes of veto-proof, and I think it's important that we include it in LB 23 and would ask the membership to support Amendment 2325. It also had a number of other cointroducers: Senator Hilgert, who prioritized the bill; Senator Witek prioritized the bill; Senator Brown, . . .

SENATOR CROSBY: Time.

SENATOR MAURSTAD: . . . who had a amendment that we adopted earlier on Select File. Thank you.

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[p. 7766] SENATOR CHAMBERS: Mr. President and members of the Legislature, I had said that Senator Maurstad is getting his orders from Washington, D.C. He needed to have those "Repelicans" in Congress tell him that issues that were raised here are all right to be added to this bill. He's not changing this bill because he has thought it through and has become convinced of anything. He is following their dictates, and you can see it from the language that he selected. It's what Congress, what the Senate today adopted. That's why he comes with this amendment. And he did make one difference in the terminology and I guess that's to show his independence. One of them says partially vaginally delivers; the other says partially delivers vaginally. Now if there is any meaning to be derived from the order in which words occur, then they're not talking about the same thing or

they're not saying the same thing about the same issue the same way. But, again, since they're following the lead of the people in Washington and feel like they've done something here, it's their bill. I still think it is an [p. 7767] atrocious piece of legislation in terms of the drafting, even if you get away from some of the other aspects of it. One of the things that I am still offended by is the fact that they do not want to acknowledge that a woman's health is important to be preserved. Since they are talking about something that they say should never happen anyway, I don't see why Senator Maurstad and others would have any objection to including language about the impairment of a vital organ of the mother-to-be. But they haven't been told that's it's all right to do that. If they had been told that it was all right to do that, it would be done. I have handed around an article to show you that in the context of the AMA's position the article talking about, and they put it in quotation marks, this partial-birth abortion, as these religious and other people characterize it for the purpose of cluttering up the statute and getting their particular view into the statute, the part that I marked is in this sentence, and it's talking about the AMA Board of Trustees: The board said in a 35-page report that there is "no identified situation" in which such abortions known medically as intact dilation and extraction, is the "only appropriate procedure." What I'm showing you is where they say "known medically". Senator Maurstad has not been told that that's how the term is known medically, so he says it's not. Well, fine. That's like when they say the earth if flat, then it's flat because they said so. But again going to Sir Thomas Moore when, they were trying to make him say something but his was

under pain of losing his head, make him say something that he didn't think was true, asked his interloctors if I say the earth is round it is no less round because the king says it's flat.

SENATOR BRASHEAR: One minute.

SENATOR CHAMBERS: And if the king says it is flat, it is not flat simply because his fiat said it is. So because Senator Maurstad and other narrow-viewed people on this floor want to tell us what is and is not a medical term, despite what the medical community has said, their disavow does not make what they say so. These terms ought to be changed. I've told Senator Maurstad after I'd offered two amendments on Select I wouldn't offer any more there, but on Final Reading, and he knows this, I'm going after this bill and there are a lot of objectionable terms I find in it and I'm going to see if we can [p. 7768] reach an accord on some of them. But in the meantime, I'm opposed to his definition because I do not think it is accurate.

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[p. 7770] SENATOR CHAMBERS: Mr. President, members of the Legislature, if what Senator Maurstad is doing is a sincere attempt made in good faith to tighten the language in this piece of legislation and bring clarity, there should be no objection to using the term "intact dilation and evacuation". It's simply that those jerking his chain did not tell him he could use those terms. That's all this is. He admits he's not a lawyer. I know he's not a lawyer, but he's not a lawyer on these other matters either, but he's been told that they are all right to be adopted and the Legislature's going to follow

suit. When we get to Final Reading I'm going to . . . I'm going to have my amendments drafted. All of this talk of an unborn child, now when I read the information put out by the Right-To-Life people, they use the term "fetus". In the legislation that the Senate passed, they use the term "fetus". This unborn child business is designed to convey a religious point of view. It is not used in the medical profession. Senator Maurstad cannot show any medical literature where that it was is used and he cannot show other states it's here because it was during a particular period when I think Senator Labedz was the one who wanted that in there more than anything else. So I'm going to try to clean this language up and maybe the Legislature will not agree to do it, but I will make a record of all the places in the existing abortion statutes which misuse language, which uses words and phraseology which have no medical meaning or validity, but rather are designed to show the contempt, hatred and disgust these people of their religious persuasion feel toward a woman who sees the necessity to have an abortion. It is nobody's business other than the woman and her medical care provider as to whether or not she'll carry a pregnancy to term. All this meddling, all this intrusion by the state is totally [p. 7771] unwarranted. And everybody may feel good here this evening because they think they've got the bill in a condition where there doesn't have to be any discussion and we can get on out of here. That will not work with me. I am as alive to the wrongfulness of this bill at this late hour, this late in the session as I have ever been. When I come here I'm prepared to deal with every issue that I think needs to be addressed, and although I was working all day long on

various pieces of legislation, we had some very emotional and heated exchanges, but that in no way diminishes my energy or my consciousness of my responsibility and obligation to fight against badly drafted, badly intended legislation. This is not good legislation. It is not necessary. But if the Legislature is intent . . .

SENATOR BRASHEAR: One minute.

SENATOR CHAMBERS: . . . on doing it, there should at least be enough honesty to admit where it came from and why it's taking the form that it's taking. This is not a result of deliberate thought, deep consideration and finally an arrival at the conclusion that these changes ought to be made. Just like marionettes, when the one who controls him told him what to do, he said bark, they bark; he said bite, they will bite; he says roll over and play dead, they roll over and play dead. Not I. Not I.

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[p. 7778] SPEAKER WITHEM: You've heard the closing. The question now is the adoption of the Maurstad amendment to LB 23. All of those in favor vote aye, opposed vote nay. A record vote has been requested. We are now voting on the adoption of the Maurstad amendment to LB 23. Have all members who wish to record their vote voted? A record vote has been requested. Mr. Clerk, please record.

CLERK: (Record vote read. See page 2160 of the Legislative Journal.) 29 ayes, 2 nays, Mr. President.

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[p. 7780] SENATOR CHAMBERS: Senator Maurstad, as I look at this legislation that is the Senate

bill where they are acting on HR 1122, I see on page 2 of that bill where this language is stricken: provided that no other medical procedure would suffice for that purpose. And what I see you striking from the bill is, "and no other medical procedure would suffice for that purpose". Why does this seem reasonable today after the Senate has acted when it didn't seem reasonable the last time we discussed this bill?

SPEAKER WITHEM: Senator Maurstad, would you respond?

[p. 7781] SENATOR MAURSTAD: Yes, I would, Mr. President, if I could take just a moment to take . . .

SENATOR CHAMBERS: Sure.

SENATOR MAURSTAD: . . . elaborate just a moment. Senator Chambers, as you're aware, I've stated on a couple of occasions the . . . where I derived the reason for the introduction of this bill in the first place. I have been very up front about that. I indicated that my original draft, that has been changed by the committee amendment, was in effect the . . . what was adopted last year by the House and the Senate, and I have felt that once it has gone through the scrutiny that is available at the federal level and you have a majority of both houses supportive of it, then after I, of course, read it, analyzed it and felt comfortable with it, that's what I used as a starting point. Once again, I think that, as always in legislation, as you've exemplified on a couple of occasions, there is always a compromise to be made if there is a reason and if it can help move a bill along. That would be my explanation to you; that this has been a concern that was raised by the American Medical Association,

who previously had been neutral on the issue, they raised this issue. It was agreed upon by those that are working on this issue at the federal level. Because, I'm taking . . .

SENATOR CHAMBERS: Okay, but my time . . .

SENATOR MAURSTAD: . . . as I indicated before, I'm more than willing to indicate that I would take their advice.

SENATOR CHAMBERS: But the fact that the Senate struck this language is really what led you to strike it, isn't that true? And the fact that they included other language which you practically verbatim have put into this bill, isn't it what the . . .

SENATOR MAURSTAD: It . . . it is . . .

SENATOR CHAMBERS: . . . Senate did that brought us to where we are today on these amendments?

[p. 7782] SENATOR MAURSTAD: It would be . . . it would be twofold. It would be the willingness of the American Medical Association to offer what they feel and their membership feel is an improvement . . .

PRESIDENT ROBAK PRESIDING

PRESIDENT ROBAK: One minute.

SENATOR MAURSTAD: . . . to the bill and the Senate's acceptance of it.

SENATOR CHAMBERS: Senator Maurstad,the Medical Association will not use the term "partial-birth abortion", but that's any good. Their judgment on that is not good, is it, because they don't know anything about medical terminology? Would you agree with that?

SENATOR MAURSTAD: No, Senator, as I indicated before, I punched my light on, I don't know if there are other lights are on, but the language that you wanted to use is also not a medical terminology. It is also not an approved medical procedure; and so what we're using as partial-birth description is one that, through the bill, can be easily understood and interpreted by those that need to look to this for direction.

SENATOR CHAMBERS: If it's easily understood, why did you add that additional language to the definition that the Senate put in it? You told us the other day, that it was crystal clear and I pointed out how vague it was, so today you come in with changes. Now it was not that clear the other day, as you thought, . . .

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[p. 7784] SENATOR CHAMBERS: I was trying to see who's paying attention. And they pause. They weren't sure. When Senator Lindsay was here, he wasn't dictated to by the lobby or Washington, D.C., nor was Senator Hall. If they felt that an amendment had validity there was no argument about it. There'd be discussion and when they were persuaded it could be adopted. The last time I spoke, just before Senator Schimek lit into me, justifiably from her point of view, I was talking about that definition that was in the bill before the Senate told Senator Maurstad that he could change the definition here. I gave detailed explanations of why that definition was inadequate. He said it's inadequate (sic), everybody can understand it, it's clear, just [p. 7785] read it. Well, if that's true, why did we have one, two, three, four, five, six, seven additional lines of definitional material? Not

because the definition was less clear to Senator Maurstad then than it is now. He didn't have permission to consider anything else. Senator Maurstad, I had explained earlier why the term "unborn child" is in the statute. It has nothing to do with medical terminology. It's a religious position and they wanted to put it in the statute, and they had the votes to do it so the statutes are cluttered just like our constitution has been defiled. But I'd like to ask you a question. On page 3, we see the term "living unborn child". Those three words are not coherent to me. They're unintelligible. What does that mean, "living unborn child"?

SENATOR MAURSTAD: That means a child that is not dead and not born.

SENATOR CHAMBERS: So before a being comes into this world, that is a child? That's a child, is that correct?

PRESIDENT ROBAK: One minute.

SENATOR MAURSTAD: Excuse me?

SENATOR CHAMBERS: That which is still in the womb is a child, according to your understanding?

SENATOR MAURSTAD: I think it can be. . . . Yes, it can be referred to as a child.

SENATOR CHAMBERS: Is that what madison . . . is that what medical people call it. Senator Maurstad?

SENATOR MAURSTAD: I think that there are medical people that would call it that, yes.

SENATOR CHAMBERS: When they're discussing this in medical terms, is that what the bill that the House passed and the Senate acted on today, do they call it an unborn child?

SENATOR MAURSTAD: Yes.

[p. 7786] SENATOR CHAMBERS: Do they?

SENATOR MAURSTAD: I believe so, but I can double check it, sir.

SENATOR CHAMBERS: This will give you a chance to correct me.

SENATOR MAURSTAD: They refer to it as a "living fetus".

SENATOR CHAMBERS: So they don't call it a child?

SENATOR MAURSTAD: No.

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[p. 7795] SENATOR CHAMBERS: And now here is what I would like to ask you about this definition, and I'm looking in your amendment, page 3 of your amendment, line 20, unborn child or a substantial portion thereof. What is a substantial portion of an unborn child? And that brings us back to where we were the other day when you couldn't tell me what "partially" meant. What is a substantial portion?

SENATOR MAURSTAD: Senator Chambers, a substantial, as a definition, is I would say a great deal of.

PRESIDENT ROBAK: Time.

SENATOR MAURSTAD: A lot of.

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[p. 7808] SENATOR CHAMBERS: Senator Maurstad, sometime back I didn't get to complete my discussion with you about what is the meaning of the terminology in line 20 of page 3 of your amendment talking about what you all refer to as unborn child, and then we have the language " . . . or a substantial portion thereof". We're talking about the substantial portion of an unborn child, is that true?

SENATOR MAURSTAD: Yes, sir.

[p. 7809] SENATOR CHAMBERS: Okay, now in trying to get to the meaning of "substantial", you said, a lot, and what else, basically, did you say it means?

SENATOR MAURSTAD: Well, if you'd like, I knew we were running out of time, Senator, so I tried to be concise. If you'd like, I can spend a couple of more moments and maybe provide a better . . .

SENATOR CHAMBERS: It wouldn't take a lot of moments is it, let me ask it, is it one-third, is that a substantial portion?

SENATOR MAURSTAD: Substantial portion, one-third.

SENATOR CHAMBERS: Not sure, really, are we?

SENATOR MAURSTAD: Yes, I think it would be a substantial portion.

SENATOR CHAMBERS: One-fourth, which is less than a third. Is that substantial? It's not really clear, is it?

SENATOR MAURSTAD: I want . . . I want . . . I don't want to be flippant, but I would say, it would depend upon . . .

SENATOR CHAMBERS: Go ahead and answer it, really.

SENATOR MAURSTAD: It would depend on which fourth.

SENATOR CHAMBERS: I understand, but, nevertheless, if you looked at one portion and somebody else at another, they might arrive at a different conclusion as to whether one-fourth is a substantial portion, do you agree?

SENATOR MAURSTAD: Yes, substantial would be subjective.

SENATOR CHAMBERS: And isn't it necessary, and if you read the AMA letter, to let people know precisely what is being banned or being prohibited, the crimi . . . oh, that's all I will ask you because you might want to put on your light and go into it with . . . at greater depth than we can now because I want to make a [p. 7810] statement. When you have, as a part of the definition, a term which is susceptible of differing meaning to reasonable people, you have an ambiguity. An ambiguity means that this that you're looking at could mean one thing or another or neither of those but a third thing. And what is substantial to one person is not substantial to another. And as Senator Maurstad pointed out,

and it might have sounded flippant but it really wasn't, it depends on what portion it is. Does it mean substantial in terms of being essential to having a full-fledged human being, or does it mean simply quantity? Does it mean, instead of portion, percentage, and then you still have the same problem? It means different things to different people, and I think that, again, creates vagueness, ambiguity, and since we're talking about a criminal statute, and we are defining here the elements, then it cannot stand, and that is the contingent that I'm making. Section, the portion that I'm trying to strike, subdivision (15) of Section 28-340, no, no, 71-148, refers us back to the language of this definition. This language . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . is also referred to when we talk about these criminal proceedings against the physician, but when you go back to the fountainhead or the definition, there is ambiguity, and that is enough to bring the whole thing down, and I don't want Senator Maurstad to accept what I am saying. I want him to leave this language just like it is. But if you ask two people what does "substantial portion" mean, they'll give different answers. Senator Maurstad is like this guy who is being questioned on the witness stand because an individual had been struck on the head with a projectile. And the prosecutor was asking the witness, what . . . what . . . how large was this projectile? The guy said, oh, it was . . . it was largish. He said, well, that doesn't help me, I mean how big was it? He said, well, it had bigness. He said, now what does largeness and bigness mean?

PRESIDENT ROBAK: Time.

SENATOR CHAMBERS: He said, oh, about the size of a lump of chalk. And when he got through, nobody . . .

[p. 7811] PRESIDENT ROBAK: Time, Senator.

SENATOR CHAMBERS: . . . still knew.

PRESIDENT ROBAK: Thank you, Senator Chambers. Senator Maurstad.

SENATOR MAURSTAD: One aspect of the discussion, Madam President, to carry forward what Senator Chambers is somewhat alluding to, and one of the things we need to keep in mind is under the description of a partial-birth abortion by Dr. Haskell, who is the one that provides the definition and the description and the way to go about performing the partial-birth abortion at a seminar, he talks about the physician physically turning the unborn child inside the uterus of the mother so that the child can be, in essence, put in a position where it would be classified as a breech delivery. And so the understanding here is that, first of all, we're putting the mother at risk by doing this. It is not a procedure that is . . . that is not even recommended, it is not recommended to be done, but we turn that child and we . . . and for to perform a partial-birth abortion and bring the unborn child into the vagina from the uterus in the breeched position. So what we're talking about here is a substantial portion of that child would be not in the uterus, passing through the cervix into the vagina. Now the reason that it's done is so that this procedure can be performed, because the cervix is not dilated to the point where the head could proceed through. In fact, the doctor indicated that you would not want that to occur because

then a live birth would happen, and that is not the intent of a partial-birth abortion. So we have to go back to look at the words "substantial portion" within the context of the whole definition, and in the context of what the procedure is defined to be and is known to be. So I think that it is very clear what substantial portion thereof would be when this procedure is taking place, once again, deliberately and intentionally. I think it's important. I have passed out the letter from Deb Thomas, the Director of Regulation and Licensure, and upon her recommendation included this section. I believe it was included in the committee amendment. It was not included, it was not a part of my original bill, but was a part of the committee amendment in the work that the committee did, and so they have drafted it in a [p. 7812] manner that is proper and appropriate. And, as such, I think it is not correct to do what Senator Chambers would ask us to do, and that is delete this section, and so I would, once again, urge my colleagues to vote against the Chambers amendment. Thank you, Madam President.

PRESIDENT ROBAK: Thank you, Senator Maurstad. Senator Chambers.

SENATOR CHAMBERS: Madam President, members of the Legislature, I would like to ask Senator Maurstad a question, because he said something that is kind of amusing to me.

PRESIDENT ROBAK: Senator Maurstad.

SENATOR CHAMBERS: Senator Maurstad, when . . .

SENATOR MAURSTAD: Sir, did I intend to be amusing?

SENATOR CHAMBERS: . . . we were talk . . . huh?

SENATOR MAURSTAD: Was it one of those moments when I was intending to be amusing?

SENATOR CHAMBERS: Well, I am not going to use my psychic powers and determine what you intended, but it could have been an unintended effect. But were you saying that while we're talking about the definition of substantial portion that Dr. Haskell, whoever that is, said that you rotate the fetus into a position approximating that of a breech birth and so forth? You had said that's what Dr. Haskell said in saying what this term, . . .

SENATOR MAURSTAD: That was his description, yes.

SENATOR CHAMBERS: . . . partial-birth . . . okay, so then this definition, shouldn't we amend it to say, all of these other things about what a partial-birth abortion means, and when we get to the final period add, or ask Dr. Haskell, as a part of the definition?

SENATOR MAURSTAD: No, no, we shouldn't do that, Senator.

[p. 7813] SENATOR CHAMBERS: Oh, and I know that, but to have a complete definition, you saw the necessity to include what Dr. Haskell said because the language of the definition, itself, is inadequate to the purpose. Isn't that true?

SENATOR MAURSTAD: No, I was trying to answer a question that you had . . . that you had raised, and because of that, I was trying to elaborate to the point that you would more easily understand. I think it is understandable as it . . . as it's written and doesn't need to be . . . doesn't need to be expanded any more.

SENATOR CHAMBERS: Now, there is nothing in this language that says that the fetus has to be emerging from the womb or the vagina feet first, is there? There is nothing that says that, is there?

SENATOR MAURSTAD: No, there isn't.

SENATOR CHAMBERS: In the procedure known as intact dilation and evacuation, it is understood that the fetus would be emerging feet first, isn't it? Isn't that what would be understood by that term? Come on, be level with me.

SENATOR MAURSTAD: Yes, sir. Yes, sir.

SENATOR CHAMBERS: Is it? Okay.

SENATOR MAURSTAD: Yeah, I'm just . . . I want to make sure I give the correct answer.

SENATOR CHAMBERS: Okay.

SENATOR MAURSTAD: And so . . . I just paused a moment to reflect is all.

SENATOR CHAMBERS: Okay, now that you've reflec . . .

SENATOR MAURSTAD: Yeah, yes, yes.

SENATOR CHAMBERS: Okay, so if we used intact dilation and evacuation, we know that that means

the fetus is emerging feet first. When you say partial-birth abortion, it doesn't say [p. 7814] which portion, substantial, whatever that means, is emerging from the vagina. So we have two different concepts here. The definition does not say what Senator Maurstad wants it to say. There is nothing in his legislation that lets you know what it is this definition is dealing with except that a substantial portion of the fetus has emerged. And we don't know what substantial portion means, and we don't know whether it was head first, feet first, or whatever. Senator Maurstad, can an intact dilation and evacuation procedure, or as you call it, partial-birth procedure occur if the head emerges first? If the head emerges first, can there be a partial-birth abortion, as you defined it?

SENATOR MAURSTAD: Yes.

SENATOR CHAMBERS: Right. With intact dilation and evacuation, the head cannot emerge first, isn't that correct?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: Okay, so there can be an intact dilation and evacuation . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . without the head . . . I meant, with the head emerging first? That's what I'm asking. If the head emerges first, can you have an intact dilation and evacuation . . .

SENATOR MAURSTAD: I would . . . I would . . .

SENATOR CHAMBERS: . . . if the head emerges first?

SENATOR MAURSTAD: . . . say, I think anything is possible in that respect.

SENATOR CHAMBERS: No, you can't, not by what this term means. What this term means is that procedure that you've been describing where the feet emerge first. But by your definition, the head can emerge first and you have a partial-birth abortion. The feet can emerge first and you have a partial-birth abortion. The baby, as you want to call it, can come out sideways, if it's [p. 7815] small enough, and you can have a partial-birth abortion. All you need by your definition is for a substantial portion to emerge. Isn't that true under your definition?

SENATOR MAURSTAD: Not just that. You also have to have the deliberate and intention of putting that unborn child into the vagina . . .

PRESIDENT ROBAK: Time.

SENATOR MAURSTAD: . . . with the purpose of killing the unborn child.

PRESIDENT ROBAK: Thank you, Senator.

SENATOR MAURSTAD: You have to have that also.

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June 2, 1997 LB 23

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[p. 9209] SENATOR KIEL: Thank you, Mr. President and members of the Legislature. I have indicated in the past that I have a lot of concerns about this bill, but I want to speak to one issue with regard to the language in this bill. I think probably this legislation is on . . . purposely drawn broadly and imprecisely. It uses terms not recognized by the very constituency, and that is physicians whose conduct the law would criminalize. It fails to distinguish between natural and induced pregnancy termination, which we have spoken to this evening, or between different stages of gestation. It purports to address a single procedure, some elements of which are used in other areas, OB-GYN, but it doesn't carefully define that procedure. Finally, it doesn't limit its scope to techniques performed after fetal viability, and I think that's a real serious problem. And that potentially affects procedures at all stages of pregnancy. I'd call your attention to the language that says viability means that stage of human development when the unborn child is potentially able to live more than merely momentarily outside the womb with the mother by natural and artificial means. I think the . . . we have a serious problem with the language in that potentially it does not particularly have a definition, and momentarily doesn't particularly have a definition either. The bill might be interpreted or enforced to include the results or procedure needed to

drain excess fluid in the brain of alive hydrocephalic . . . well anyway, fetus during the course of delivery when spinal fluid is drained in a manner resulting in fetal death. Zealous enforcement could arguably extend to cases of incomplete spontaneous abortion where the removal of the fetus is accomplished by the same techniques as an induced abortion or to many other gynecologic or obstetric procedures where the fetus is living when the procedure begins. My biggest concern is that this will be interpreted or enforced beyond a specific technique of endorse . . . induced abortion. A political discussion has reflected a lot of confusion about medical terminology and technique, and the likelihood for misinterpretation or deliberate misinterpretation is high. This law would have a [p. 9210] chilling effect on the practice of medicine, leaving doctors with an understandable fear of prosecution to avoid medical procedures or surgical techniques that could in any way fall within the scope of such legislation. I think the impreciseness, the broadly defined language in this legislation is a real problem. And with that I would yield the remainder of my time to Senator Chambers.

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[p. 9217] SENATOR CHAMBERS: Senator Maurstad, wherever the fetus is spoken of as being alive, in the definition for one place and there may be other places in the bill, that doesn't mean that the fetus is breathing does it?

SENATOR MAURSTAD: Senator Chambers, are you in Section 1?

SENATOR CHAMBERS: Yes, but . . .

SENATOR MAURSTAD: Okay.

SENATOR CHAMBERS: . . . I want to find out when we use the term "alive" or "living", does that mean that the fetus is breathing, the unborn fetus?

SENATOR MAURSTAD: Well, it's my understanding that the fetus is alive and is breathing and is on the support of the mother through the umbilical cord.

SENATOR CHAMBERS: That before it comes into the world it's breathing? I'm just asking for your understanding.

SENATOR MAURSTAD: Yeah. From my perspective, I would think that the . . . it would be breathing, yes.

SENATOR CHAMBERS: Thank you: I'd like to ask Senator Dierks a question. Senator Dierks, is a fetus breathing when it's in the womb?

SENATOR BRASHEAR: Senator Dierks, will you yield?

SENATOR DIERKS: It is not breathing as you and I call breathing. It's just living on the blood of its mother.

SENATOR CHAMBERS: Thank you, but . . . and there might be an exchange of oxygen by way of the blood, but there is no breathing.

SENATOR DIERKS: That's right.

* * *

[p. 9231] SENATOR CHAMBERS: And the words "or a substantial portion thereof".

SENATOR MAURSTAD: Yes.

SENATOR CHAMBERS: Now, does it mean that the person deliberately and intentionally delivers into the vagina or a substantial portion of the vagina this unborn child? What does "or a substantial portion thereof" refer to?

SENATOR MAURSTAD: The substantial portion . . . I think it's . . . I believe that the "substantial portion thereof", in fact, refers to the living unborn child.

SENATOR CHAMBERS: And again, because we went through this before you use substantial, we don't really know what substantial means, do we?

SENATOR MAURSTAD: Well, we discussed that on Select File and . . .

SENATOR CHAMBERS: And we don't know any more on Final than we knew on Select, wouldn't you agree?

SENATOR MAURSTAD: Well, I think I know the same thing I knew on Select File that substantial is easily defined and would not be something that would be necessarily contestable.

SENATOR CHAMBERS: Well, then would you define it for me in the easy manner that it can be done in an incontestable manner?

SENATOR MAURSTAD: Well, I think substantial would indicate that more than a little bit has been delivered into the vagina. I [p. 9232] don't mean to be flippant. I'm just trying to be as honest as I can in my interpretation of what substantial would be.

SENATOR CHAMBERS: How much is a little bit because we . . . we're . . . more than that?

SENATOR MAURSTAD: Well, enough . . .

SPEAKER WITHEM: One minute.

SENATOR MAURSTAD: Enough that would allow for the procedure to end up with the killing of the unborn child.

SENATOR CHAMBERS: So then, that means the fetus could be coming out head first, right?

SENATOR MAURSTAD: That certainly could be the case and it could, at that point, delivery stopped and either the child dismembered or the child be killed in the manner that I spoke of earlier.

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[p. 9236] SENATOR CHAMBERS: Okay. I could read the whole definition, but I'm going to start in line 12 where it tells us what this means, and I'm starting with the word means, " . . . means deliberately and intentionally delivering into the vagina a living unborn child or a substantial portion thereof". What does, for the purpose of a criminal statute's precision, do the words "or a [p. 9237] substantial portion thereof" mean?

SENATOR BRASHEAR: I believe it would be substantial in terms of physical . . . I'm hunting for a word . . . physical form or physical function so that we would be talking about the head or the chest area. In other words, it's something more than a foot or a hand.

SENATOR CHAMBERS: Could it be a leg?

SENATOR BRASHEAR: I think not because that's what I was trying to say, and probably not very articulately, I think "substantial portion" would apply both to the portion of the body and to the function of that portion of the body.

SENATOR CHAMBERS: But you would agree with me, I'm sure, that the language of the definition does not say that.

SENATOR BRASHEAR: That's correct.

SENATOR CHAMBERS: Don't you agree?

SENATOR BRASHEAR: That's correct.

SENATOR CHAMBERS: And two judges may look at it and arrive at different conclusions as to what that means, would you agree with that?

SENATOR BRASHEAR: There's no question there will be a fact question as to what is a substantial portion.

SENATOR CHAMBERS: And when you're talking about the definition of the element of a crime, isn't is necessary that the person who runs the risk of being charged with it has to know in advance and with precision what is prohibited and what is permitted? Isn't that the standard requirement of all criminal statutes?

SENATOR BRASHEAR: Yes, but with all due respect, Senator Chambers, I think you are, in being efficient, you're taking on a very narrow portion of the phraseology because in applying this as a criminal statute, there's going to be the concept of [p. 9238] "delivering into the vagina a living unborn child; or a substantial

portion thereof, for the purpose of performing a procedure that . . . "

SENATOR CHAMBERS: But you . . .

SENATOR BRASHEAR: So you're going to get into the question of, could the procedure have been performed on the head? Yes. Could the procedure be performed on the arm . . . the arm and wrist or hand and wrist? No.

SENATOR CHAMBERS: Well, you could cut the veins, but here's the thing, Senator Brashear. The part of the definition that all the rest of it is keyed to is that a "substantial portion thereof" was delivered into the vagina. And that's all I will ask you, by the way, and thank you for your help. The fact that we disagree and that Senator Brashear has to explain it indicates that it does not have the precision a criminal statute needs, and I'm glad he said that I am taking a very narrow view or narrow construction. The Supreme Court has said repeatedly, any statute in derogation of the common law is narrowly construed, and criminal statutes are in derogation of the common law. Anytime you codify something by statute, you . . . that is derogating from the common law, and that's why all . . .

SPEAKER WITHEM: One minute.

SENATOR CHAMBERS: . . . criminal statutes are narrowly construed. No more will be read into what the words actually say. And if by reading these words in the narrowest manner possible, it is unclear what they

mean and reasonable people can differ, then it is unconstitutionally vague. So I'm sure that that cannot pass constitutional muster.

SPEAKER WITHEM: Senator Chambers, you would now be recognized to close on your amendment.

SENATOR CHAMBERS: Thank you, Mr. Speaker. And this portion of this bill is extremely important, and, Senator Brashear, as was done with the term limits bill and the things that were gotten into the record that the court made reference to, I want to make it very clear what I'm saying about this language. Let me ask [p. 9239] you this one question, then I will release you on this aspect of it. Would you agree that if this definition is struck down as unconstitutionally vague or ambiguous, the whole act would fall? If . . .

SENATOR BRASHEAR: I'm thinking, Senator Chambers.

SENATOR CHAMBERS: If the definition falls, the whole act, which depends on the definition, must fall also. Isn't that true?

SENATOR BRASHEAR: Yes, I would think so.

SENATOR CHAMBERS: Okay, thank you. And Senator Maurstad helped show how vague this definition is. Senator Brashear helped show how vague it is. He's even including function, yet there's nothing in the definition that talks about a function of the portion that is delivered into the vagina. The only thing that this bill says about the portion is that there must be . . . it must be substantial. It doesn't say the head, it doesn't say one leg, two legs. What it happening here is that Senator

Maurstad and maybe others are envisioning what the term "partial-birth abortion" means to them, so when they read these words, in their mind they conjure up a picture of the fetus being extracted feet-first, but that's not what the amendment says. The amendment doesn't say head-first, feet-first, or sideways. Let me ask one question of Senator Maurstad. Senator Maurstad, there is nothing in this bill that speaks of the time, the stage of development of this fetus, is there?

SPEAKER WITHEM: Senator Maurstad, can you respond?

SENATOR MAURSTAD: No. Yes. No, there isn't, Senator.

SENATOR CHAMBERS: So it could be in the first trimester?

SENATOR MAURSTAD: Yes.

* * *

[p. 9243] SENATOR CHAMBERS: Okay. Now, if we go further down into line 24, this evidence . . . well, I guess you'd have to go up to line 20. Whether the attending physician's conduct was necessary to save the life and the mother and so forth. "What is developed at that hearing shall be admissible in the criminal proceedings brought pursuant to this section." Do you believe that in order for that which is produced at that hearing to be admissible, it would have to have been given under oath? Do you think, in other words, statements made which are not under oath would be admissible in the criminal proceeding?

SENATOR BRASHEAR: I do not, Senator Chambers, but that's not what the reference here is. The reference here is to the findings of the director.

SENATOR CHAMBERS: I know.

SENATOR BRASHEAR: And I believe, administratively, that can be made admissible.

SENATOR CHAMBERS: But here's what I'm asking you, if the findings of the director are based- . . . because we can say anything we want to in a statute, but the constitutional analysis will be based on whether or not that which we put in statute measures up [p. 9244] to the constitution. If findings by the director were based on statements not taken under oath, you believe that those findings would still be admissible?

SENATOR BRASHEAR: I believe that they could and would be, but I understand the issue you're raising and I am not a member of the court.

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June 3, 1997 LB 23

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[p. 9393] SENATOR CHAMBERS: . . . you looked at this definition in this bill? It would be found on

page 4. I will read it to you, the part that is significant. That what is being defined is this string of words: "partially delivers vaginally a living unborn child before killing the unborn child". That's what's being defined, and this is the definition. Those words mean "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof". What does "substantial portion thereof" mean, in your opinion? First of all . . .

SENATOR ABBOUD: Which . . . which line is that on, Senator [p. 9394] Chambers?

SENATOR CHAMBERS: Lines 13 and 14, on page 4. Toward the end of the line we see "or a substantial portion thereof". What does that mean?

SENATOR ABBOUD: Well, I think that's . . . I don't think that's probably defined in . . . anywhere else in statute and may be defined some place in case law with some . . . some other . . . maybe some court cases have defined what that particular language means. To me, speaking without the benefit of knowing how other courts have defined it, I would assume it would be a substantial . . . "substantial" would mean a significant portion of that child.

SENATOR CHAMBERS: And what does "significant" mean?

SENATOR ABBOUD: I really couldn't give a definition to that beyond what I've given, Senator Chambers.

SENATOR CHAMBERS: Nor can I, so don't think that I've got an answer. If you were representing a

client and your client had to face an indictment or an information or a complaint which accused him or her of this . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . offense and included in that document charging the offense was this language, "or a substantial portion thereof", would you, as the defense attorney, know what you were being asked to defend your client against in terms of "a substantial portion"? Could you say that there was not a substantial portion since nothing tells us what that means?

SENATOR ABBOUD: I would think that . . . I really wouldn't know the answer to that, Senator Chambers, about . . . to see if there'd be some . . .

SENATOR CHAMBERS: Well, let me ask this question.

SENATOR ABBOUD: I would . . . I'd be willing to say, I don't know if you've talked to the sponsor about this particular issue, but [p. 9395] the . . . I assume the language was drawn in such a manner to deal with a possible court challenge and maybe . . . maybe Senator Maurstad is the person that could best answer your . . .

SENATOR CHAMBERS: But he's not a lawyer.

SENATOR ABBOUD: Well, he may not give you the answer you want either, so that could be . . .

SENATOR CHAMBERS: Well, he said it means more than a little bit, but that wasn't . . .

PRESIDENT ROBAK: Time.

SENATOR CHAMBERS: . . . very helpful.

PRESIDENT ROBAK: Thank you, Senator Chambers. Senator Maurstad.

SENATOR MAURSTAD: Thank you, Madam President. I move to oppose the motion to return to Select File. As we discussed for a short while last night before we adjourned, this is an issue of clarifying a specific illegal action. It is consistent and not contradictory to other provisions that are in the . . . in this section, subsection (8) for example, the performing, procuring, or aiding and abetting in the performance or procurement of a criminal abortion. This doesn't conflict with that. It's consistent with that. It's a specific reference as opposed to a general reference. It is important relative to the bill and needs to be . . . needs to remain in the statute. I . . . to harken back just a moment to some of the discussion that Senator Chambers is digressing on that we discussed relative to the definition, after the exchange that Senator Chambers just relayed where I indicated what he has reiterated, I also then went back and indicated that in my opinion a foot could be a substantial portion because once that foot comes out it can't be put back and, as a result, that would be, in my opinion, a substantial portion of this child. So, with that, without any . . . I think we did have about as much discussion on this amendment as we had on some of the others last night. I think that we were getting to a point where Senator Chambers may have realized the importance of this and so if I could ask, excuse [p. 9396] me, ask Senator Chambers a question.

PRESIDENT ROBAK: Senator Chambers.

SENATOR CHAMBERS: Yes.

SENATOR MAURSTAD: Senator Chambers, after the discussion we had that last night relative to the clarification on this particular issue, are you considering withdrawing this amendment and moving on to the last one?

SENATOR CHAMBERS: No, because this one would be . . . would hinge on what the definition means . . .

SENATOR MAURSTAD: Okay.

SENATOR CHAMBERS: . . . and so I would want to explore the definition.

SENATOR MAURSTAD: I was unclear as we were . . . as we were ending last night. I may have misinterpreted a comment that you made and so I wanted to clear that up before we went any farther. So, with that, I'll again indicate that I oppose the motion to return the bill to Select File to strike Section 5, which includes the action that would become illegal as a result of LB 23. Thank you, Madam President.

PRESIDENT ROBAK: Thank you, Senator Maurstad. Senator Chambers.

SENATOR CHAMBERS: Madam President, I would like to ask Senator Maurstad a question in view of his elaboration of what "substantial" means.

PRESIDENT ROBAK: Senator Maurstad.

SENATOR CHAMBERS: Senator Maurstad, you said that as small a portion of the fetus as a foot would constitute a substantial portion in your opinion. Is that correct?

SENATOR MAURSTAD: Yes, I believe that's correct. That's what I indicated.

[p. 9397] SENATOR CHAMBERS: So a hand would be the same thing.

SENATOR MAURSTAD: True.

SENATOR CHAMBERS: And those are about the smallest portions of the fetus that could be exposed.

SENATOR MAURSTAD: Um-hum.

SENATOR CHAMBERS: Why then didn't your bill say "any portion" rather than "substantial"? "Any" would be less vague than "substantial".

SENATOR MAURSTAD: Well, I think that . . . I don't agree. We have a disagreement on whether "substantial" is vague or not. I think it is a term that is easily understood and easily interpreted within the context of the balance of the definition and . . .

SENATOR CHAMBERS: But you said it could be a hand or a foot, and Senator Brashear talked about the head or the chest or a part of the body that . . . where vital actions/activities were occurring, so you and he have a different definition of it, so how can you say it's clear and easy to define?

SENATOR MAURSTAD: Well, I don't know that we have a clear difference. From my perspective, I don't know that we do, because if the head was the first part of the anatomy that was not in the . . . let me make sure I get this . . .

SENATOR CHAMBERS: Within the woman, and I'll understand . . .

SENATOR MAURSTAD: Within the woman. Okay.

SENATOR CHAMBERS: . . . what you're talking about.

SENATOR MAURSTAD: Within the woman, then I think that any individual part of the child would be a substantial part, an important part of that child and would fit the description.

SENATOR CHAMBERS: So then you would say an "important" part of [p. 9398] the child just as easily as saying "substantial".

SENATOR MAURSTAD: Senator, I think that it is a possibility that different words could have been used to end up with the same definition. You'll have an opportunity now to . . . chastise is too strong of a word, but once again; we need to harken back that I used as the model for LB 23 that was originally introduced, and I'm sorry for taking some of your time.

* * *

SENATOR CHAMBERS: Okay, thank you. I want to ask a lawyer a question 'cause I. . . . Oh, Senator Bromm is . . . oh, there he is. Senator Bromm, you were a prosecutor, so I want to ask you a question. If you were drafting an indictment, an information, a complaint against a physician for violating this statute and a part of the complaint would have to be a statement of what the person is supposed to have done wrong and you would allege that a substantial portion thereof, referring to an amount of the fetus that had emerged from the woman,

what would that term "or a substantial portion thereof" mean?

[p. 9399] PRESIDENT ROBAK: One minute.

SENATOR BROMM: Okay.

SENATOR CHAMBERS: Even though it's in the language of the statute, what does that term mean? What does "substantial portion" mean?

SENATOR BROMM: Well, I can only tell you what I think and a judge would eventually interpret that, but it would be more than an insignificant portion or a very minor portion. It would be . . . it would be a . . .

SENATOR CHAMBERS: Would it be more than a hand?

SENATOR BROMM: Well, one would think so.

SENATOR CHAMBERS: So then a person . . .

SENATOR BROMM: That's a difficult question to answer.

SENATOR CHAMBERS: So now let's put you in the position of a defense attorney. What would . . . how would you defend your client against this charge crafted in this language, that "a substantial portion of" the fetus had emerged from the woman and that's all you're given, "a substantial portion"?

* * *

SENATOR CHAMBERS: Thank you, Madam President. You can see that Senator Bromm has a different view of what this means, and I'd venture to say everybody who is asked the question would have a different

view. Senator Bromm, you know, not only from your [p. 9400] experience as a prosecutor but in being familiar with the law, that criminal statutes must be precise and unambiguous. Do you agree?

SENATOR BROMM: [illegible]t's correct.

SENATOR CHAMBERS: And a person who runs the risk of having that law apply against him or her must be able to tell from reading the law what is allowed and what is prohibited. Would you agree?

SENATOR BROMM: I would agree with that.

SENATOR CHAMBERS: Do you think that a physician reading this language, and by that I meant these words, "or a substantial portion thereof", will know from that language what is allowed and what is prohibited?

SENATOR BROMM: I think it would be difficult, Senator Chambers. I think their inclination would be simply not to take the risk.

SENATOR CHAMBERS: Now in the first trimester the state cannot prohibit a woman from having an abortion. This amendment, I meant this definition does not designate any point or period of the pregnancy and Senator Maurstad acknowledged last night that it would apply throughout the pregnancy. So if it applies to the first trimester when the state cannot prohibit the abortion do you think that a person could be charged with a crime for performing a procedure defined in the manner this one is if it's during that point in the pregnancy where the state cannot prohibit it or criminalize it? In other words,

this will criminalize an abortion at a period when the Supreme Court has said you cannot criminalize it.

SENATOR BROMM: Well, my, Senator Chambers, I haven't had an opportunity to follow all the discussion . . .

SENATOR CHAMBERS: Okay.

SENATOR BROMM: . . . today, but my reaction is that I think what the bill is attempting to do is to prohibit a procedure no matter what stage of the pregnancy that the fetus is in; that [p. 9401] this procedure is not allowed, and that's the way I understand it.

SENATOR CHAMBERS: Is the fetus always. . . . First of all, what does "alive" mean with reference to a fetus, in your opinion?

SENATOR BROMM: Well, I think that once the fetus has . . . can sustain any viability that it is alive.

SENATOR CHAMBERS: Oh, viability, is different because the way they define that term is that it can live outside the mother independently or with the assistance of whatever they say.

SENATOR BROMM: Um-hum.

SENATOR CHAMBERS: But in the early stages or the middle stages, when the fetus is still within the womb of the mother, is it alive? It's not breathing, . . .

SENATOR BROMM: Well . . .

SENATOR CHAMBERS: . . . but is it alive?

SENATOR BROMM: Well, you know, it depends on what perspective. From my perspective it is.

SENATOR CHAMBERS: Is the life of the fetus always terminated prior to its being removed from the woman.

SENATOR BROMM: In . . .

SENATOR CHAMBERS: . . . at every stage of an abortion?

SENATOR BROMM: At every stage of an abortion?

SENATOR CHAMBERS: Yes.

SENATOR BROMM: I do not know.

SENATOR CHAMBERS: If a fetus, during the early stages of a pregnancy, were removed from the woman and it were still alive, whatever that would mean for a fetus, and it was too small, too [p. 9402] poorly developed to live outside the womb . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . that would be a violation of this statute, wouldn't it?

SENATOR BROMM: Well, I thought that this statute prohibited this procedure that we have heard so much about rather than blanket covering any . . . any other procedures that might be applied in an abortion.

SENATOR CHAMBERS: But because they did not designate any stage of the pregnancy, it applies to every stage, every stage.

SENATOR BROMM: If they use this procedure.

SENATOR CHAMBERS: Well, all you have to do is have, as they say, bring the fetus into the vagina,

remove it, and terminate it. It's not where the feet come out first and the only thing remaining is the head at a late stage in the abortion. This is not a prohibition against late-stage or late-term abortions.

SENATOR BROMM: No.

SENATOR CHAMBERS: This applies throughout and that is . . .

PRESIDENT ROBAK: Time. Thank you, Senator Chambers. Senator Schimek. Senator Schimek.

SENATOR SCHIMEK: Yes, Madam President, members of the body, I would yield my time to Senator Chambers, if he wants it.

PRESIDENT ROBAK: Senator Chambers, do you wish to continue speaking?

SENATOR CHAMBERS: Yes, I thank Senator Schimek for that. What I'm trying to show is the lack of wisdom in crafting state legislation based on a multiplicity of sources, not one of which understands the constitutional law of Nebraska. To discuss a procedure which everybody who has talked about it at the federal level, Senator Maurstad, has discussed it in terms of a [p. 9403] late-term abortion, where all of the fetus is outside the mother except for the head. Then, to use the graphic language of those who support this kind of legislation, the skull is pierced, the contents are extracted, the skull is collapsed, and then the remainder of the fetus is removed from the mother. But that is not what your definition defines. If you called it that ID & E, that would let people know from the term itself what it is you're talking about, but you did not want to use that term so you used

language which is not medical, which is not scientific and called is a partial-birth abortion. You do not designate the stage of the abortion . . . of the pregnancy where this procedure is performed. And it doesn't say anything about which portion of the fetus emerges first. But when all of that discussion was going on in the Judiciary Committee hearing, all of that discussion on Select File, I don't know what they talked about on General File because I was not here, it was a procedure of the kind that I described. Yet, when you pass a bill which you say is designed to prohibit that procedure it doesn't define that procedure at all, and that's why I said the purpose of this bill is to prohibit a woman from having an abortion. That's what it's for. If you look at the definition, it covers an abortion at any point during the pregnancy any time the fetus is not terminated within the womb of the mother, and the reason I say "terminated", we cannot even come to a consensus as to what being alive means when we're talking about a fetus. Those who support this bill call it an unborn child. So if they believe that human life starts at conception and that which is conceived is an unborn child, then a zygote is not a zygote. A zygote is an unborn child. And I defy anybody to get on the Internet or anywhere else and find that as a definition of the uniting of the sperm and the egg, that is an unborn child. No way. But if that's what you're going to say it is, these fertilized eggs that they have frozen, are not those unborn children that are existing in a test tube somewhere frozen solid? It shows how ridiculous legislation becomes when the language is selected to convey a religious message rather than to comply and conform to what is legally necessary.

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: So when we get over here to this portion that I want to strike, where we're talking about dealing with [p. 9404] unprofessional conduct, how are they going to determine that the conduct was professional or unprofessional when they don't even know what the procedure means? They don't even know what it is. And you know why they don't know what it is? Because the definition does not tell us. And if they look at the legislative history, the introducer cannot tell us. I don't know if Senator Bromm is on this bill as a cosponsor but he's a lawyer and former prosecutor. No, he's not on here. Yes, he is. He doesn't know what it means. Senator Brashear doesn't know what it means. And it's not because they are ignorant people and it's not because Senator Maurstad is an ignorant man. It means that we're being given something which is not clear.

* * *

[p. 9413] SENATOR KIEL: Thank you, Madam Lieutenant Governor, members of the Legislature. I will just reiterate what I had said before and it goes to the impreciseness of the language in this bill. I think people have come to this debate very honestly and with a [p. 9414] lot of thought beforehand, but I think those people who are on this bill are ultimately going to be disappointed in the outcome because I do believe that, because of the vagueness and impreciseness of the language in the bill, that it will be found unconstitutional. Again, I wish that we could find some common ground in crafting language that would be more precise, that would be more direct, that people could actually sit down and say this is

the definition of this language, this is the definition of this word, but unfortunately we've not been able to do that. I will also say that I think probably this legislation will be found unconstitutional because it does not include any language with regard to protecting the health of the mother, and we haven't talked a whole lot about that at this stage of discussion. With that said, I will yield the rest of my time to Senator Chambers.

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[p. 9417] SENATOR CHAMBERS: Madam President, I have to ask Senator Maurstad a question . . .

PRESIDENT ROBAK: Senator Maurstad.

SENATOR CHAMBERS: . . . so that it will be clear from . . . for the record what I'm getting at. Senator Maurstad, you did mention this life-threatening situation. Now in whose opinion must it be deemed life-threatening?

SENATOR MAURSTAD: In the . . .

SENATOR CHAMBERS: That of the physician, or somebody . . .

SENATOR MAURSTAD: In the physician's.

SENATOR CHAMBERS: . . . who's going to review his conduct afterward?

SENATOR MAURSTAD: Clearly, with the amendment that was adopted on Select File, it is the physician who determines that.

SENATOR CHAMBERS: So all the . . . and this I want for the record. You're the sponsor of the bill. The

word of the physician is final when it comes to the determination of whether the woman was faced with a life-threatening situation. That is your intention.

SENATOR MAURSTAD: The physician need not be concerned relative to their judgment in this area, given the caveat, obviously, that they have to comply with the definition and with LB 23. But if they indicate that it's a life-threatening circumstance and if its challenge is upheld by the process, the appeal process, then they make the decision.

[p. 9418] SENATOR CHAMBERS: So then it is not really the physician's decision. He or she can be brought up on charges and have to prove to somebody else to their satisfaction that it was really life-threatening in their judgment rather than that of the physician. Isn't that true?

SENATOR MAURSTAD: But that's not unlike . . . that's not unlike other provisions in law that restrict the physician in one way or another.

SENATOR CHAMBERS: But doesn't that help you to better understand what I meant when I said that, even when a woman is facing a life-threatening situation, the physician may be unwilling to help because of the threat of the criminal prosecution? And it is there. But here's another question I want to ask you. When this, going to the part I'm trying to strike about this finding that the director is to make as a result of this proceeding, if the director finds that the physician in fact was faced with a situation that would allow this procedure without it being criminal, does that finding by the director mean

that the criminal charge should be dismissed? Will that end the issue . . .

SENATOR MAURSTAD: You're . . .

SENATOR CHAMBERS: . . . as far as the criminal charge?

SENATOR MAURSTAD: . . . you're indicating that the appeal process indicated that there was no violation of the . . . of this part of the statute and does . . .

SENATOR CHAMBERS: In the opinion of the director.

SENATOR MAURSTAD: Okay. And, so I have the question clear, then that would mean that there would be automatic dismissal of the criminal action? Was that your question?

SENATOR CHAMBERS: Yes.

SENATOR MAURSTAD: And the answer is, no, that that . . .

[p. 9419] SENATOR CHAMBERS: Right.

SENATOR MAURSTAD: . . . that that would have to be determined by the court. The findings of the director would be admissible in court and the, of course as I indicated last night, there would need to be a judgment made first by the prosecutor as to whether to proceed with the case given the findings of the director, but then, if so, then it would be the court that would make that final judgment on the criminal aspect.

SENATOR CHAMBERS: Thank you, Senator Maurstad. You've been very forthright, and it shows the

charade of this whole thing giving the impression, when we were discussing it superficially, and that's why I want to take it a step at a time, section by section, and get the sponsor to tell us what really is in the mind of those who support this bill. Having the hearing does not really have a bearing on criminal guilt or innocence. You're going to have . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . people trained in medicine to conduct a hearing, and if all of the evidence is presented and those who make the decision on a medical basis determine that there was a life-threatening situation facing this physician and they rule that the physician did not violate the law as written and given to them to make a judgment, it doesn't mean anything. The criminal prosecution goes on and, Senator Maurstad, isn't it true that the doctor could still be convicted, despite the finding of the director in favor of the doctor? The doctor could still be convicted in the criminal action, isn't that true? I'm, excuse me, Senator Maurstad's mike isn't on and we lost about 30 second.

SENATOR MAURSTAD: Senator, anything is of course possible. My evaluation would be, in that circumstance, not very probable.

SENATOR CHAMBERS: No, I'm asking you under this law . . .

SENATOR MAURSTAD: Yeah, well . . .

SENATOR CHAMBERS: . . . the doctor could still be convicted of a [p. 9420] crime, despite the finding in his favor . . .

SENATOR MAURSTAD: Yes, they're . . .

SENATOR CHAMBERS: . . . by the director.

SENATOR MAURSTAD: . . . two distinct and separate actions.

* * *

[p. 9435] SENATOR CHAMBERS: Madam President and members of the Legislature, I have to say that even my colleague, Senator Wesely, with whom I agree, has fallen into the trap of talking about a gruesome procedure. The definition does not talk about a gruesome procedure. What I have continued to try to hammer into the heads of my colleagues, and I've been totally unsuccessful, is that we have to look at the definition. And Senator Maurstad will have to help me with this. Senator Maurstad, and I wanted to save this question until we got on Senator Wesely's amendment, where in your definition anywhere, anyplace, does it say that any portion of the fetus is outside the mother?

PRESIDENT ROBAK: Senator Maurstad.

SENATOR MAURSTAD: I don't think the fetus can be outside the mother, Senator Chambers.

[p. 9436] SENATOR CHAMBERS: In this procedure.

SENATOR MAURSTAD: In this procedure, I don't think that . . .

SENATOR CHAMBERS: No portion of it is outside the mother.

SENATOR MAURSTAD: Well, okay, let . . . let me backtrack again. Could you ask the question again for me, so I . . . ?

SENATOR CHAMBERS: Yes. We have been talking and I've been luring everybody into the trap and they've fallen into it. I've been describing the procedure that you all say you're attempting to prohibit and that's where a portion of the fetus is outside the mother, except the head. And we've talked about that. Then I asked could a hand be outside, could a foot be outside? The answer was yes.

SENATOR MAURSTAD: Okay. I understand now.

SENATOR CHAMBERS: Okay. Now, according to your definition, no part of the fetus need be outside the mother. Isn't that true?

SENATOR MAURSTAD: We're talking about deliberately and intentionally delivering into the vagina . . .

SENATOR CHAMBERS: So . . .

SENATOR MAURSTAD: . . . so we're talking about a substantial portion thereof in the vagina.

SENATOR CHAMBERS: So no part of the fetus has to be outside the mother, does it, based on your definition?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: So this so-called gruesome procedure that Senator Wesely and Senator

Schimek, and I'm mentioning them because they support your bill but they're in favor of a woman's choice, have not looked at the definition for what it says. And, oh, and that's all I will ask you . . .

[p. 9437] SENATOR MAURSTAD: Okay.

SENATOR CHAMBERS: . . . at this point. What the definition does not say is that any portion of the fetus has to be delivered from the vagina, but only into the vagina. No part of the fetus is outside the woman. But when they came before the Judiciary Committee, when they talked about it before Congress that they . . . and they give pictures, they show the bulk of the fetus outside the mother feet first. That's what they're talking about. That's not what the definition is talking about. The definition is not talking about any of the things that have been discussed on this floor other than what I have discussed, and that's any abortion at any point during a pregnancy where the fetus passes through the vagina, and that's a crime if a physician participates in that type of abortion. If . . . let me ask Senator Maurstad a question.

PRESIDENT ROBAK: Senator Maurstad.

SENATOR MAURSTAD: Yeah.

SENATOR CHAMBERS: Senator Maurstad, if a fetus is delivered by way of Caesarian section, that would be an abortion too, wouldn't it?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: Or would it?

SENATOR MAURSTAD: No.

SENATOR CHAMBERS: It can only be an abortion if it's via the vagina? Is that true? I'm asking for information.

SENATOR MAURSTAD: The abortion, as I indicated in the definition, the important aspect of that is the killing of the unborn child.

SENATOR CHAMBERS: I thought it was the premature termination of the pregnancy by whatever means, based on the definition in the law, just an abortion, period.

[p. 9438] SENATOR MAURSTAD: Yeah.

SENATOR CHAMBERS: Here's what it says on . . .

PRESIDENT ROBAK: One minute.

SENATOR CHAMBERS: . . . page 3, and it's from existing law: . . .

SENATOR MAURSTAD: Um-hum.

SENATOR CHAMBERS: . . . "Abortion means the use or prescription of any instrument, medicine, drug, or other substance or device intentionally to terminate the pregnancy of a woman . . .

SENATOR MAURSTAD: Right.

SENATOR CHAMBERS: . . . known to be pregnant".

SENATOR MAURSTAD: Right.

SENATOR CHAMBERS: So it could be by way of a Caesarian section and that's an abortion too, isn't it, . . .

SENATOR MAURSTAD: I . . . I . . .

SENATOR CHAMBERS: . . . based on the definition?

SENATOR MAURSTAD: As I indicated before, Senator, you know, whether it's possible and whether it's practical and whether it's done, you know, is irrelevant relative to this bill . . .

SENATOR CHAMBERS: But here's what I'm saying.

SENATOR MAURSTAD: The point is you could dismember a child and I suppose if you wanted to have a C-section to take out the dismembered parts. You could do that.

SENATOR CHAMBERS: Not dismember.

SENATOR MAURSTAD: I don't think that would be appropriate.

SENATOR CHAMBERS: If . . . if all you're intending to do is [p. 9439] terminate the pregnancy and if you do it by way of Caesarian section, that's an abortion by the definition in the law, isn't it?

SENATOR MAURSTAD: If it is . . .

PRESIDENT ROBAK: Time.

SENATOR MAURSTAD: . . . if it is done intentionally to terminate the pregnancy, it would be.

* * *

[p. 9445] SENATOR CHAMBERS: Is it your understanding that when abortions are performed, in

every instance the fetus is terminated within the womb? Is that your understanding?

SENATOR WITEK: Yes.

SENATOR CHAMBERS: So there's never been an instance where a fetus would emerge and not be dead in an abortion? A legal abortion?

SENATOR WITEK: That's why we came to this point in time because this is a procedure that is . . .

SENATOR CHAMBERS: No, that's . . . I am not talking . . .

SENATOR WITEK: . . . not . . .

[p. 9446] SENATOR CHAMBERS: No, I'm asking you about abortions, in general, because in the Judiciary Committee, when we have hearings, we hear many anecdotal examples that they give of what they call a botched abortion, and the fetus is still alive when it comes out of the woman and they terminate it outside the woman, but you're saying that doesn't happen. Is that what you're saying?

SENATOR WITEK: No, actually, I have heard where in some abortions that the child is not killed in utero, it is taken apart, suctioned out. I am not sure, I think at some point in time during that procedure, the child dies, but I think it's a very . . .

SENATOR CHAMBERS: But you are not aware of any instance where you called it a child, I call it a fetus, but, in any case, where it is still not dead. It is not dead when it emerges from the woman.

SENATOR WITEK: No, I am aware of instances where that has occurred. There have been people who have testified that they have delivered.

SENATOR CHAMBERS: Do you think there are any fetuses which are killed in the vagina during abortions?

SENATOR WITEK: I know that there is a saline solution that is used to supposedly kill the child, and is that what you're referring to?

SENATOR CHAMBERS: I'm just asking you, are you aware of any situations? Because I hear all these anecdotes. I don't know whether they are true or not, but that's all I'll ask you because I don't want to try to bring you into something where you're as unsure as I am of whether these things actually happened. But if, and I've heard even medical personnel talk about how they have worked in clinics and they have seen this happen, so maybe they are not telling the truth. But if these anecdotes are true, then it means when an abortion is performed, which is legal under the law, and the fetus is killed after it enters the vagina, that violates this statute here, at any point [p. 9447] in the pregnancy. This statute does not give a stage of the pregnancy where it comes into effect, so it applies throughout the term of the pregnancy, and no part of the fetus has to be outside the mother. All that's needed, based on this definition, is that the fetus or a substantial portion of it be in the vagina, not outside. So what you all have been talking about is not what this bill talks about, and I can't get that through you all's head. You're talking about something other than what is defined . . .

SPEAKER WITHEM: One minute.

SENATOR CHAMBERS: . . . in this bill, and this bill's definition includes far more that what you all are talking about, and if there is this miscarriage that is beginning, it could begin in an obstetrician's office. Somebody could be performing an examination and it could start, and there could be a complication. And if the doctor helped bring the fetus into the vagina, knowing that the result is that the fetus is going to die, that doctor, even though it's a miscarriage, is guilty, under this bill, of committing a crime based on the way you all define it. And you can shilly-shally and dance and dodge around it all you want to, it's fortunate that the courts and not these legislators who will stand up and say the bill is clear and sit down, and that means the bill is clear. Ridiculous and preposterous, read the language of the bill.

* * *

[p. 9459] SENATOR CHAMBERS: Senator Hilgert, without reading the whole definition, because you have heard that read over and over, what does "substantial portion" mean with reference to the fetus? What does "substantial portion" mean?

SENATOR HILGERT: You know I listened to that debate, and I understand that there was some problem quantifying that. I also looked in our statutes, criminal statutes, regarding . . . our obscenity statutes, actually, and they use words like "predominantly" and other suggestive terms, so I believe that . . . that it's probably a litigable term.

SENATOR CHAMBERS: Senator Hilgert, were they talking about an attitude, an idea, an opinion, or a physical item? We are talking about a physical item here.

SENATOR HILGERT: They were discussing physical items, because it had to do with actual pornographic material and . . .

SENATOR CHAMBERS: No, they . . . they were talking about the reason, the attitude. Weren't they talking about the attitude, Senator Hilgert? Be as straightforward as you said our discussion has been? What . . . when . . . okay, let me back up then. You read the statute. Tell me what the language was talking about in the statute that you read.

SENATOR HILGERT: I can't recall word for word. There's 16 hours of debate, and I believe you hammered on this point several times.

SENATOR CHAMBERS: But in the statutes where you found the term predominant, were they talking about the size of a drawing, the size of a tape, or what were they talking about?

SENATOR HILGERT: Okay, I understand where you are coming from [p. 9460] now. It probably is more of an attitude or characteristic, as such, the predominately puritan interest. I was looking for a definition of what you said is substantial, and although I've only found the word "substantial" used on Uniform Commercial Code, you, and as we discussed off the mike, you said, well, that's . . . that's not criminal, you know, Senator, you know that. So let's look for criminal and I did look for some.

SENATOR CHAMBERS: And we're talking about an object here.

SENATOR HILGERT: Yes.

SENATOR CHAMBERS: A quantifiable, measurable object. What would "substantial" be? Isn't it true that you cannot define it any better than the people who tried on the floor?

SENATOR HILGERT: I . . . yes, that is somewhat true. I think that everyone has an idea in their mind, that it's hard to quantify. That's why I said it's probably a litigable issue.

* * *

[p. 9462] SENATOR CHAMBERS: Everything flows from the definition, and if there are several people looking at it, and they have a different opinion as to what it means, that defines ambiguity and lack of clarity, wouldn't you agree?

SENATOR HILGERT: I would say that if several experts on the board, using your example, all came up with very disparate conclusions upon what the definitions referred to, based on LB 23, if it is to be passed into statute, I think that would, itself, define ambiguity.

* * *

[p. 9467] SENATOR CHAMBERS: Other things you would have done differently, if you were given this bill as it exists right now, and you're aware of the discussion we've had and the questions raised, would you draft the bill differently yourself, if you had total freedom to draft it in the way you thought fit?

SENATOR HILGERT: I would be more likely to draft a different bill, perhaps finding out what the courts will do when some of these questions are brought before them.

SENATOR CHAMBERS: So you wouldn't change the bill, if you were drafting it? You wouldn't change the definition. You would leave "substantial portion thereof"?

SENATOR HILGERT: Yes, frankly, I would because what you do is you end up saying, well, and I don't want to be grotesque or anything, but say, well, let's say we'll use percentages. If you had 30 percent of a fetus, using your terms, or a child, 30 percent, in the vagina, then you would . . .

SENATOR CHAMBERS: Would you have said that part of the fetus would have to be outside the woman, would you have said that?

SENATOR HILGERT: Probably not, I think that once the intent is to bring it . . .

SPEAKER WITHEM: Time, Senator Chambers. Senator Schimek.

SENATOR SCHIMEK: Yes, I yield my time to Senator Chambers.

SPEAKER WITHEM: Senator Chambers.

SENATOR CHAMBERS: Thank you, Senator Schimek. Senator Hilgert, when everybody talks about this procedure . . . you got your instructions again.

SENATOR HILGERT: No, I just wanted to make sure you had a chance . . .

SENATOR CHAMBERS: I'm toying with you.

SENATOR HILGERT: . . . to continue our conversation, Senator.

[p. 9468] SENATOR CHAMBERS: No, I am lightening the mood.This procedure that everybody has talked about has been depicted in drawings. It was discussed before the Judiciary Committee, and it was a very specific procedure they were talking about, and the majority of the fetus was outside the mother, or didn't you attend that hearing?

SENATOR HILGERT: Oh, I attended the hearing. You were . . .

SENATOR CHAMBERS: Isn't that why we have television sets?

SENATOR HILGERT: Yes.

SENATOR CHAMBERS: This is the technological age.

SENATOR HILGERT: No, you were at the enterprise zone hearing, I believe, during this hearing.

SENATOR CHAMBERS: But that hearing lasted a lot longer than the time I was at the enterprise zone hearing.

SENATOR HILGERT: Yeah, it did, but, yes, I did see those illustrations that I believe were taken out of some instructional manual . . .

SENATOR CHAMBERS: Right, they weren't talking . . .

SENATOR HILGERT: . . . to teach people how to do this.

SENATOR CHAMBERS: And they weren't talking about anything other than that which was depicted, when they came before the committee, isn't that true?

SENATOR HILGERT: Well, I think they were talking about it in the entirety. I think they were referring to that illustration a lot as the most . . . as the worst illustration, the most grotesque illustration as an example.

SENATOR CHAMBERS: But even when . . .

SENATOR HILGERT: That's why you use words like "substantial" [p. 9469] and so forth . . .

SENATOR CHAMBERS: No, but that would have had to say outside the woman's body.

SENATOR HILGERT: Right.

SENATOR CHAMBERS: This . . . your bill says just a portion of the fetus is in the vagina, not outside the body.

SENATOR HILGERT: We tried to be as encompassing as possible.

SENATOR CHAMBERS: Well, this bill doesn't deal with what was described and discussed in the committee though, does it?

SENATOR HILGERT: Well, I believe . . .

SENATOR CHAMBERS: It covers more than what they talked about in the committee, doesn't it?

SENATOR HILGERT: I would agree with that, Senator, yes, it does. This bill does encompass more than specific examples that people related and the illustrations presented by, and I forget the source where it came from.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

[Caption Omitted In Printing]

EXHIBIT 6

Mrs. Kiel asked unanimous consent to be excused until she returns. No objections. So ordered.

Mr. Maurstad withdrew his motion to suspend the rules.

BILL ON FINAL READING

The following bill was read and put upon final passage:

LEGISLATIVE BILL 23. With Emergency.

A BILL FOR AN ACT relating to abortions; to amend sections 28-325, 28-340, 71-148, 71-155, and 71-171.02, Reissue Revised Statutes of Nebraska, and section 28-326, Revised Statutes Supplement, 1996; to prohibit partial-birth abortions; to provide a penalty; to provide for professional license suspension and revocation; to harmonize provisions; to provide severability; to repeal the original sections; and to declare an emergency.

Whereupon the President stated: "All provisions of law relative to procedure having been complied with, the question is, 'Shall the bill pass with the emergency clause attached?' "

Voting in the affirmative, 45:

Abboud	Cudaback	Jensen
Beutler	Dierks	Jones
Bohlke	Elmer	Kristensen
Brashear	Engel	Landis

Bromm	Hartnett	Lynch
Brown	Hilgert	Matzke
Bruning	Hillman	Maurstad
Coordsen	Hudkins	McKenzie
Crosby	Janssen	Pedersen, Dw.
Pederson, D.	Stuhr	
Peterson, C.	Suttle	
Preister	Tyson	
Robak	Vrtiska	
Robinson	Wehrbein	
Schellpeper	Wesely	
Schimek	Wickersham	
Schmitt	Witek	
Schrock	Withem	

Voting in the negative, 1:

Chambers

Excused and not voting, 3:

Kiel Raikes Will

A constitutional two-thirds majority having voted in the affirmative, the bill was declared passed with the emergency clause and the title agreed to.

UNANIMOUS CONSENT – Members Excused

Messrs. Landis and Lynch asked unanimous consent to be excused until they

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